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**Drug Treatment – What works?
an Evaluation measuring the effectiveness of
drug counseling, consultancy and continuing care services at
the Buoyancy Foundation of Victoria Inc.**

(This report replaces the *Interim Report*, December 1999)

1. Background

In 1996 Buoyancy Foundation engaged a consultant, Dr Anthony Dare, as an Evaluator to assist with establishing goals and purposes that could be measured and thus facilitate the on-going evaluation of Buoyancy's effectiveness.

Buoyancy was interested in ensuring that it had a coherent drug treatment strategy, a range of policies, operating practices and services that were consistent with that strategy, as well as ways of assessing the on-going effectiveness of those services. Buoyancy wanted to be able to assess its effectiveness for three reasons: firstly, for its own professional integrity, secondly, in order to be accountable to its stakeholders and thirdly to contribute to strategies for the evaluation of drug treatment services generally.

From this starting point, the Evaluator worked with Buoyancy through a number of stages in this project, culminating in a trial system of gathering specific, measurable data on indicators of effectiveness. The trial began in September 1999. An *Interim Report* covering the three months 7 September to 7 December 1999 was submitted to the Victorian government's Expert Committee in December 1999.

The current report covers the six months 7 September 1999 to 7 March 2000. It is considered that a six-month trial is sufficient to indicate current levels of effectiveness, and the trial has now been terminated, pending possible refinement of the process.

2. Buoyancy's Mission

The starting point for measuring effectiveness of drug treatment was to devise a mission for Buoyancy Foundation. As of 1996, Buoyancy had already been in existence for twenty-nine years. It was decided to build on past achievements, to plan for the future and to encapsulate a vision for the future in a mission statement. Purposes, projects and programs would then be linked to the mission, and evaluation would be based on measures linked to the statement of purposes.

As part of reviewing its strategy in 1996, staff became aware of the existence of ARTA, a Dutch drug treatment agency that had reported extraordinary results. While Buoyancy did not intend, at least in the short term, to develop itself into a residential treatment center with an intensive program like ARTA, there were aspects of ARTA's operation that attracted Buoyancy stakeholders. In particular, ARTA operates as a *community* offering a positive environment, life style and range of activities. These present a drug user with a positive alternative that is in stark contrast with the negative aspects of the drug culture.

While working on the mission, Buoyancy staff developed the fundamental distinction of the drug culture as a culture of *users* - not only users of drugs, but also users of services, users of friends and family, and users of people's concern and attention. In summary, staff distinguished a drug-induced culture of living and relating where drugs narrow the repertoire of behaviors to those that are essentially *self-centered, self-concerned self-indulgent and inward looking*.

In contrast, the staff developed the distinction of a culture of *contributors*, people engaging in life with other people, giving time and attention to family and social relationships, and offering one's talents and capabilities in joint projects with others. In summary, staff saw *contributor* as a culture of living and relating that is essentially *connective, collaborative, participative, creative and outward looking*.

Staff concluded that people who were engaged in the "user culture" would not alter their relationship to life unless they saw an alternative that was more attractive, inspiring and fulfilling. *They resolved that Buoyancy itself would be a demonstration of that alternative.*

Consistent with that ambition, Buoyancy adopted the following mission:

***"To offer opportunities for people to participate
in a culture of self-expression and contribution."***

3. Activities and services

From 1996, in addition to its traditional role as a drug-counselling Service, Buoyancy developed a range of other counselling services and therapeutic activities, which the Service terms “modalities”. Clients are free to choose which modality they wish to engage with, and clients often participate in a number of modalities, one after the other or simultaneously. As of March 2000, the following modalities/activities were available at Buoyancy:

- Ø Counselling, consultancy and continuing coordinated care (with approximately fifty-fifty percent client gender ratio and twenty five per cent young people)
- Ø Telephone/Internet/e-mail counselling
- Ø Vietnamese drug education programs (including the Young Vietnamese Women’s Program)
- Ø Non drug users’ support and seminars
- Ø Garden arts (in conjunction with Collingwood Children’s Farm) programs
- Ø Art therapy
- Ø Homeopathy
- Ø Yoga
- Ø Shiatsu massage
- Ø Meditation/relaxation groups
- Ø Photographic exhibition program
- Ø Support groups for cannabis users (Munchies) and Queer Users of Intravenous Drugs (QUID)
- Ø Needle and syringe exchange
- Ø Reiki

- Ø Court report
- Ø Extension of services to Deer Park Women's Prison

Other services/functions are planned to commence in due course, including:

Intranet tracking of brokerage clients, upgrade of internet site, client food co-operative, publication of natural detoxification book, development of Residential retreats at Mt Alexander land, legal training of drug and alcohol workers, drug training of legal workers (in conjunction with community legal centers), promotion of new United Nations Resolution for international support of harm minimization/ drug treatment, projects with young Vietnamese women; quality standards, policies and procedures (identification , transcribing, benchmarking, targeting, implementation, distribution and promotion).

4. Sounds fine, but does it work?

By the start of 1999 Buoyancy's professional staff had a certain amount of evidence that clients were gaining value from their participation at the Service. Participation rates were increasing, totals of episodes of care and achievement of significant treatment goals were far exceeding quarterly targets, some former clients were assisting as volunteers and there was no difficulty in filling the Management Committee or executive positions thereon. In short, existing measurements plus anecdotal evidence convinced the staff that the Buoyancy approach was on the right track. However Buoyancy had no systematic way of monitoring the effectiveness of its interventions with clients.

In mid-1999 Buoyancy re-engaged the Evaluator to work with the staff team to devise a model for measuring the Service's effectiveness, using group consensus to arrive at a system that would have professional integrity and wide credibility.

5. Monitoring effectiveness

For the staff, these were the critical questions: *Is Buoyancy effective? Do clients who participate at Buoyancy actually improve or get better?* Or, despite impressions and opinions to the contrary, does their involvement with Buoyancy actually make no real difference? Both for purposes of professional integrity (to enable Buoyancy to be accountable to external stakeholders) and to contribute to the general development of drug services, they felt that those questions needed to be addressed.

Another critical question was: *Can Buoyancy develop a mechanism that would enable it*

to monitor changes in its effectiveness, as it refines current practices and implements new ones?

6. Existing context

As with other Counselling, Consultancy and Continuing Care (CCCC) drug treatment services, Buoyancy has a Funding and Service Agreement with the Department of Human Services. These agreements typically include Performance Measures, that is, targets to be fulfilled, based on Episodes of Care. An episode of care involves the following cycle: *registering* the client, creating an *individual treatment plan* (ITP), achieving *significant treatment goals*, and *terminating* the episode. Thus, in the current financial year, Buoyancy has contacted to provide 275 episodes of care, or 68.75 per quarter. Its agreement also includes the commitment that 90% of clients achieve significant treatment goals. Obviously, the monitoring of the Service's performance in terms of its Funding and Service Agreement will continue in the normal way. Buoyancy was interested in *adding to the above system* by devising measures that, from the client perspective, looked at the impact of their involvement with Buoyancy.

The quality of service for each CCCC drug treatment Service is also researched via a Client Satisfaction Survey. This survey obviously has the potential to yield useful information on effectiveness. The February 1999 report of this survey indicated positive results for Services overall. However, the *Individual Summary Report* on Buoyancy included data on only 6 clients, hence its potential was yet to be realized.

Over a series of team meetings, staff devised the following principles:

- Ø Buoyancy's effectiveness was to be linked to the percentage of clients whose life situation had clearly improved.
- Ø Progress would be rated via a small number of dimensions.
- Ø The dimensions needed to be acceptable to workers with a wide range of approaches to drug services.
- Ø The dimensions assessed needed to be clear, unambiguous and uncontroversial.
- Ø Clients would be assessed after each visit to Buoyancy
- Ø The measure of effectiveness would be the *degree of positive shift* between the client's first visit and latest visit.

The overall purpose of the monitoring system was to enable Buoyancy to monitor its

level of effectiveness as a *drug service agency*, not to monitor the progress of any *individual client*.

7. The dimensions

Choosing the dimensions to be measured and devising the items to rate each dimension was a protracted process. Eventually, the dimensions proposed by *Success Works* (following their consultations with a wide range of drug service agencies) were adopted, and a small number of items devised for each dimension. The dimensions were:

- ∅ Physical well-being
- ∅ Emotional/psychological well-being
- ∅ Nature of substance use
- ∅ Incidence of high risk behavior
- ∅ Social functioning

The staff agreed that a sufficient shift over a sufficient number of these dimensions would be accepted as constituting “improvement” or “getting better”, or, as it is now termed, “exhibits a positive shift”.

8. The items

Each item, its method of rating and its scoring system had to be accepted by each of the seven professional staff of Buoyancy. Considerable time and discussion were devoted to devising a brief set of simple, unambiguous, credible, easily-scored items that would enable each dimension to be rated. Ultimately, the items devised for each dimension were as follows:

∅ Dimension of *physical well-being*

*This dimension is related to whether the person is **sleeping** and **eating** normally.*

Rationale: It was the professional opinion of the staff that these two aspects were the most fundamental aspects of physical well-being, and ones that are the foundation of all other aspects of physical well-being. The staff rate the response as “yes” or “no”, using a wide range of latitude in defining “normal”.

For all items, staff use their professional judgement and integrity to give the ratings in the general context of “user culture” v. “contributor culture”. They look for *gross*, not fine distinctions. As an example of a gross distinction, “I have eaten just toast and ice cream for the last three days” would probably rate as “eating normally” (despite the obvious dietary implications) as contrasted with “I have not eaten *anything* for three days”, which would probably be rated “not eating normally”.

∅ **Dimension of *emotional/psychological well-being***

*This dimension is related to whether the person has **plans** or **goals** for his/her life.*

Rationale: It was the professional opinion of the staff that the psychological aspect that most distinguishes a person immersed in the drug culture is an absence of attention or interest on the future. The staff rate the client’s response as “broad goal”, “narrow goal” or “no goal”, again, using a wide range of latitude. For example, for a particular client, “I am going to try to score this afternoon” might be rated as “no goal”, “I am thinking of coming back here tomorrow” might be rated as “narrow goal” and “I going to try to rebuild my relationship with my parents” might be rated as “broad goal”.

∅ **Dimension of *substance use***

*This dimension is related to **shift in level/nature of substance use** at each visit compared with first visit.*

Staff have chosen the following guidelines, using a harm-minimization perspective:

- 0 *has not changed substantially compared with first visit*
- +1 *level has reduced and/or nature has improved (i.e. less harmful)*
- +2 *level has reduced significantly and/or nature has improved significantly*
- 1 *level has increased and/or nature has deteriorated (i.e. more harmful)*
- 2 *level has increased significantly and/or nature has deteriorated significantly*

Rationale: Staff expect that a person’s involvement at Buoyancy would result in reduction in amount and an improvement in the nature of substance use.

Ø Dimension of *high risk behaviour*

*The following were chosen as the most critical examples of **high risk behaviours** associated with drug use:*

- Ø *Use of shared or unclean injecting equipment*
- Ø *Engaging in unsafe sex*
- Ø *Poly-drug use*
- Ø *Using drugs with no one else around*

Rationale: In the professional judgement of the staff, these four behaviours constitute of highest priority indicators of high risk.

Ø Dimension of *social functioning*

*This dimension is related to whether a person **has workable accommodation arrangements** and **has people in his/her life that he/she can trust**.*

Rationale: Staff chose these as the two most fundamental aspects of social functioning, the physical aspect and the social aspect.

The Feedback Questionnaire is reprinted as Appendix A.

The Guidelines for Use of Questionnaires are reprinted as Appendix B.

9. System of rating

The maximum total that a client can receive on the questionnaire is 20 points. However, the absolute score is of little relevance. We are interested in *degree of shift* in scores over time/visits.

The issue to be resolved was this: *What is the degree of shift we would need to observe before we are willing to say the client has improved or got better?* Obviously a small shift would be insufficient, both because the questionnaire itself is a relatively “blunt instrument”, and because small shifts would not have wide credibility. On the other hand, it might be unrealistic to expect large shifts, especially over a few visits.

After considerable discussion and three trials, the following standards were adopted:

- ∅ *A shift of +6 or more is termed “a significant positive shift”*
- ∅ *A shift of +3, +4 or +5 is termed “a positive shift”*
- ∅ *A shift of -2, -1, 0, +1 or +2 is termed “no shift”*
- ∅ *A shift of -3 or less is termed “a regression”*

Again, it is important to remember the purpose of the monitoring system. For one particular client, a shift of +1 in some vital area might conceivably represent a significant positive shift, and for another, a shift of +5 might conceivably represent virtually no outcome. But that is not the purpose of the system. The purpose is to enable Buoyancy to amalgamate the results *across all clients* and thus to monitor the level of effectiveness of its operation.

10. Criteria

At the commencement of the trial (September 1999) and in advance of the results, Buoyancy staff agreed to set *minimum acceptable criteria*, to be reviewed in the light of actual results. The purpose of these self-imposed targets was to bring a level of rigour to the evaluation and to establish a context for interpreting the actual results. In effect, they represent a set of *service quality standards* for the Service.

The system was implemented for an initial three-month period (7 September-7 December 1999), and then extended for a further three months to March 2000. Encouraged by the initial results, which became available in December 1999, staff revised the criteria, the overall effect being to make them more rigorous:

		<i>Initial criteria</i>	<i>Revised criteria</i>
		<i>(Sept 1999)</i>	<i>(Dec 1999)</i>
<i>Percentage to exhibit a significant positive shift</i>	Minimum acceptable %	20%	30%
<i>Percentage to exhibit a positive shift</i>	Minimum acceptable %	40%	35%

<i>Percentage to exhibit no shift</i>	Maximum acceptable %	30%	25%
<i>Percentage to exhibit a regression</i>	Maximum acceptable %	10%	10%

11. Results

	3 months* <i>7 Sept 99 -7 Dec 99</i>	6 months <i>7 Sept 99 -7 Mar 00</i>
Total number of completed questionnaires	145	214
Representing this number of individual clients	62	94
<i>Number of clients completing 2 or more questionnaires</i>	39	53
<i>Percentage of clients completing 2 or more questionnaires</i>	63%	56%

* Some statistical errors in the Interim Report have been corrected

<i>N. of questionnaires completed per client*</i>	3 months		6 months	
	<i>N. of clients</i>	<i>%</i>	<i>N. of clients</i>	<i>%</i>
1	23	37%	41	44%
2	21	34%	27	29%
3	7	11%	8	9%
4	4	6%	8	9%
5	4	6%	5	5%

6	1	2%	2	2%
7	0	0%	1	1%
8	1	2%	1	1%
9	1	2%	0	0%
10	0	0%	0	0%
11	0	0%	1	1%
Totals:	62	100%	94	101%**

***Note:** The procedures in place during the periods were not rigorous enough to allow us to infer an even approximate match between the number of questionnaires completed and the number of visits made by the client.

** Rounding errors.

Comparison of results between the first visit and the latest visit showed the following shifts:

Shift	3 months		6 months	
	N. of clients	%	N. of clients	%
+10	1	3%	2	4%
+9	0	0%	1	2%
+8	3	8%	1	2%
+7	4	10%	5	9%
+6	4	10%	4	8%
+5	6	15%	9	17%

+4	1	3%	2	4%
+3	4	10%	7	13%
+2	3	8%	2	4%
+1	5	13%	9	17%
0	3	8%	3	6%
-1	2	5%	3	6%
-2	0	0%	0	0%
-3	2	5%	2	4%
-4	0	0%	0	0%
-5	0	0%	2	4%
-6	1	3%	1	2%
Totals:	39	101%*	53	102%*

*Rounding errors.

Summary results: What percentage of clients “improved” or “got better”?

Degree of shift	Shift between first and latest visit	Interim criteria %	Results: 3 months		Revised criteria %	Results: 6 months	
			N	%		N	%
“Significant positive shift”	+6 or more	20%	12	31%	30%	13	25%

“Positive shift”	+3,+4 or +5	40%	11	28%	35%	18	34%
“No shift”	-1, -2, 0, +1 or +2	30%	13	33%	25%	17	32%
“Regression”	-3 or less	10%	3	8%	10%	5	9%
Totals:		100%	39	100%	100%	53	100%

12. Comments

Perhaps the first thing to acknowledge is the courage of the staff of Buoyancy in being willing to set criteria in advance of the results. The Evaluator has known of only a very few organizations that are willing to impose such targets on themselves. This is hardly surprising, given the risks involved. It is fine in theory to commit to particular targets in the interests of rigour; it is another thing to have to deal with the consequences if the results are not produced.

The highlights over the six-month period, September 1999 to March 2000, were as follows:.

- Ø Encouraged by the 3-month result of 31% on a criterion of 20%, Buoyancy increased the criterion for *significant positive shift* from 20% to 30%. This turned out to be somewhat optimistic. Buoyancy was not able to sustain the first three months' performance, the 6-month result being 25%. Nevertheless, by attending to processes to increase effectiveness over a period of time, 30% is probably achievable.
- Ø Buoyancy substantially met the criterion for *positive shift* (34% on a target of 35%).
- Ø Obviously, a reduction in the percentage of clients exhibiting *no shift* would be desirable, and Buoyancy set itself the target of reducing that percentage from 33% to 25%. This turned out to be an over-ambitious target, as the result over the six months remained almost stable, at 32%. Obviously, it will take a considerable effort to reduce this to the desired 25%.
- Ø The percentage of clients exhibiting *regression*, 9%, was satisfactory, given that it remained below the criterion of maximum 10%.

Buoyancy can take considerable satisfaction in these results. In summary, one can say that currently, about one-quarter of Buoyancy's clients attending two or more sessions achieve *significant positive shifts* (some after as few as two sessions), and another one-third of clients achieve *positive shifts*. Thus, about 60% of all clients attending two or more sessions exhibit either *positive* or *significant positive shifts*, a considerable achievement both for them and for Buoyancy. It would be particularly gratifying for Buoyancy if they could reduce the proportion of *no shift* clients.

The challenge now is to identify and reinforce those practices and processes that are effective, and to identify and eliminate those processes and practices that are ineffective or deleterious.

This questionnaire-based measurement system has the potential to assist in this development.

In summary, the Evaluator believes that this model of measuring effectiveness gives the staff the opportunity to use their professional judgement and integrity to set and actively pursue various *quality-related criteria*, quarter by quarter, and gives them a powerful management tool for the further development of Buoyancy Foundation.

[end of body of report]

Appendix A

Feedback questionnaire

Appendix B

Buoyancy Foundation of Victoria Inc.

GUIDELINES FOR ADMINISTERING QUESTIONNAIRES

Current Draft - 10 December 1999

Administering the questionnaire

Counsellor/therapist to interview client and fill in responses. (Do not have clients fill it in themselves, as many of the items require the professional judgement of the counsellor/therapist).

Scoring of items

The scoring of items 1,2,4 & 5 as indicated on the questionnaire.

Item 3 on the questionnaire is scored differently. This item measures whether a client's substance use has *altered* during their attendance at the Buoyancy Foundation. In making judgements about substance use, use a *harm minimization* perspective.

At their first visit, the counsellor/therapist will note the nature and level of the client's substance abuse. (The counsellor may wish to make brief notes to aid in recalling this initial level.) The client is given a first rating of 0, which constitutes the baseline. For subsequent visits, the counsellor/therapist will compare the nature and level of the client's substance abuse with that at the time of the first visit, rating it +2, +1, 0, -1 or -2, depending on the shift relative to the first visit.

*Compared with the **level** of substance (amount/frequency) and **nature** of substance abuse (in terms of harm minimization) at the time of the **first visit**:*

0 has not changed substantially

+1 level has reduced and/or nature has improved (i.e. less harmful)

+2 level has reduced significantly and/or nature has improved significantly

-1 level has increased and/or nature has deteriorated (i.e. more harmful)

-2 level has increased significantly and/or nature has deteriorated significantly

Overall scoring of the questionnaire

To be included in the questionnaire results, staff need to complete a minimum of 2 questionnaires per client. All item scores will be added to produce a score out of 20. To measure the degree of change, we will report the shift in total scores between the first and last occasions for each client. We will then state whether the client has achieved a Significant Positive Shift (SPO), a Positive Shift (PO), No Shift (NO), or has Regressed (R).

Frequency of Administering

Clients generally attend an average of two appointments. Could staff ensure that they fill in the questionnaire on the first and second appointments. If a client continues to use the service, could staff please administer the questionnaire on every second appointment, that is on visits 1, 2, 4, 6, 8 etc.

Standards for SPS, PS, NS, Regression

These standards are levels we have chosen for the purposes of assessing the effectiveness of Buoyancy's services. They are not intended to be an accurate reflection on the progress of any individual client:

(SPS) - If a client's total scores indicate a shift of +5 or more points between their first and latest visits, this is a 'significant positive shift'. [later altered to +6]

(PS). If a client's total scores indicate a shift of +3 or +4, points between their first and latest visits, this is a 'positive shift'. [later altered to +3, +4 or +5]

(NS). If a client's total scores indicate a shift of -2 -1, 0, +1, or +2 points between their first and last visits, this is 'no shift'.

(R). If a client's total scores indicate a shift of -3 or less between their first and last visits, this is a 'regression'.

How to handle multiple questionnaires from the same client on the same day or in the same week?

So as not to burden clients with multiple questionnaires, please ensure that no client completes more than 2 questionnaires in any one week.

Use of identifiers

Identify each questionnaire with "John B", "Jane S." etc. They must be consistent, but do not have to be the clients' real names. Make sure that two people do not have the same identifier. We need this information to cross-reference clients that use more than one modality.

Completion

We need to ensure that staff complete all items on the questionnaire. Any questionnaires with uncompleted items cannot be used in the evaluation and should not be submitted, as they will lead to invalid comparisons.

[end of guidelines]

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