How to *show* treatment works

What do commissioners want to know from services, and what information should services provide to demonstrate effectiveness? Nobody has a more influential opinion than the head of the project which advises England's drug and alcohol service commissioners.

by **Don Lavoie**

Associate Director of the Substance Misuse Advisory Service (SMAS), a HAS 2000 project which helps health and social care commissioners in England develop their commissioning strategies.

One of the hottest concepts in the health service today is 'clinical effectiveness'. Health and social care commissioners are consistently told only to purchase services of proven effectiveness. To do this they need to know what works, for whom, under what circumstances, and is it cost-effective? Simple; in principle, so too was the quest for the Holy Grail. The problem is, few if any drug and alcohol services can answer such questions, satisfactorily or otherwise; most have probably not even thought how they *might* answer them. This article is intended to kick-start that process or crystallise it for those already on the way.

The three big questions

Commissioners need to gather data from contracted service providers in order to answer three basic questions:

- Who uses the service (client demography)?
- What does the service do to/with them (activity)?
- Who benefits from the service, how many, and in what ways (outcomes)?

Such 'contract monitoring' is not consistently applied across the drug and alcohol field. If it were, what might the data look like?

1 Who uses the service? First, commissioners would establish a minimum data set on client characteristics for all their contracted services. For drug services, data already collected for regional drug misuse databases would partly suffice, but not for clients whose main problem is alcohol and (at the moment) not for clients continuing in treatment. And the databases are concerned only with drug using clients, not the families and communities which may also (or instead) be service beneficiaries.

2 What does the service do? Most commissioners get rather meaningless activity data from their providers. NHS drug and alcohol services are usually linked into a larger mental health trust. In a 'feed the beast' operation for the Department of Health, these trusts must provide data such as *finished consultant episodes*, *occupied bed-days*, *outpatient attendances* and *community psychiatric nurse contacts*. From the independent sector, commissioners might receive information on *number of clients seen*, *hours of counselling offered* or *length of stay by occupied bed-nights*. Most of these measure what the service puts *in* to the treatment not the 'outputs' in terms of client engagement and progress.

Commissioners would ideally collect compatible information from all their service providers, statutory and independent, covering the number of new clients who were:

> ▶ ▶ ▶ *pressure for client outcomes has led to easily collected but invalid, non-standard measures*

- referred to the service (or made contact);
- seen by the service;
- completed the assessment process;
- admitted to the service;
- referred out to other services;
- had a care plan developed by the service.

Then for existing clients (the ones who'd got to the last stage above), the number:

- in compliance with their care plan (active clients) at the start of the year;
- completing treatment during the year;
- walking out of treatment (self-discharge);
- asked to leave (disciplinary discharge);
- returning for further assistance;
- remaining active clients (still working towards their care plan) at the end of the year.

Some services already provide such data but – never having been asked for it – many lack the required infrastructure. Given that this is relatively modest, most should be able to comply within a short period.

3 Who benefits and how? Pressure from commissioners to report client outcomes has led anxious providers to respond with easily collected but invalid, non-standard measures, often little more than customer satisfaction questionnaires which do not measure relevant outcomes at all. Sometimes they are clients' unstructured accounts of 'how they are doing', which could lend themselves to a range of interpretations.

Outcome measures need to be objective if they are to be accepted as truly reflecting the service's impact on its clients. What's needed is a 'common information currency' subscribed to by the agency and by its investors. The securest route to this is to use 'validated' instruments – questionnaires or other tools which research has shown reliably to reflect the outcome being measured.

Currently the best known British effort to gather outcomes is the National Treatment Outcome Research Study (NTORS). NTORS developed the Maudsley Addiction Profile (MAP) to assess progress in 1075 clients entering treatment in four types of drug services (▶ *Nuggets* 1.3, p. 9). MAP measures five domains of health and social functioning: drug and alcohol use; physical health; mental health; social stability; and criminal activity. It has been validated and is available free of charge.[1] Other instruments are being developed to measure similar outcomes.

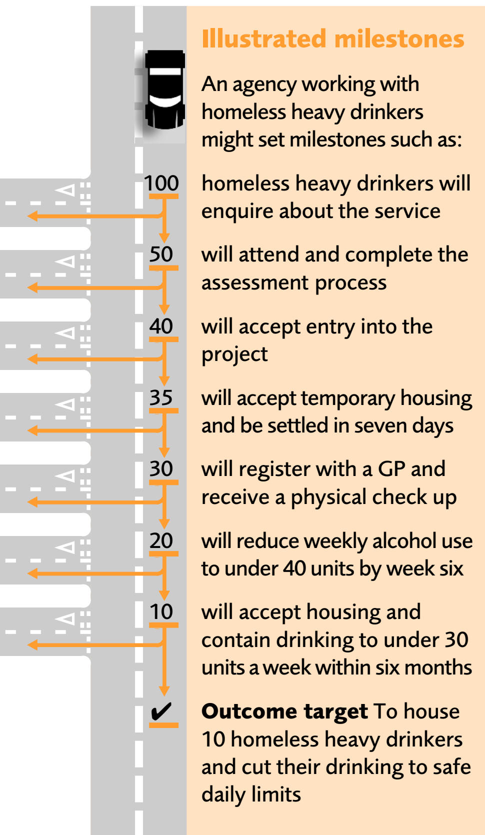
Collecting outcome data in a uniform way is a good start, but does not relieve providers and commissioners from the responsibility of interpreting the data[2] and deciding how much change is expected – issues which could result in interesting negotiations.

Management by milestones

One technique for coherently integrating activity and outcome measures is 'milestone management', an ingredient in the 'outcome funding' approach. This encourages commissioners to see themselves as investors seeking a 'return' from services in terms of social or health gain. The first major UK experiment with outcome funding came in the mid-90s with the allocation of the Drug and Alcohol Specific Grant.

Milestone management first encourages dialogue between the commissioner and the service provider to profile the service's intended clients. Providers then set targets for the outcome(s) these clients will achieve due to their involvement in the service. *En route* clients will pass a series of milestones, key stages that mark the progress already achieved and underpin further advances. Throughput targets are set for the numbers predicted to reach each milestone and the provider monitors how far these targets are being met. The

Contact SMAS at 11 Grosvenor Crescent, London SW1X 7EE, phone 0171 838 9597, fax 0171 245 0428.



Illustrated milestones

An agency working with homeless heavy drinkers might set milestones such as:

100 homeless heavy drinkers will enquire about the service

50 will attend and complete the assessment process

40 will accept entry into the project

35 will accept temporary housing and be settled in seven days

30 will register with a GP and receive a physical check up

20 will reduce weekly alcohol use to under 40 units by week six

10 will accept housing and contain drinking to under 30 units a week within six months

✔ **Outcome target** To house 10 homeless heavy drinkers and cut their drinking to safe daily limits

panel above shows how this might look for a service targeting homeless heavy drinkers.

Milestone management helps commissioners know up front what a service aims to achieve. The issue then is whether these outcomes would merit the investment. Regular milestone monitoring prompts the provider to modify the service to encourage clients to reach milestones and target outcomes. It also provides a basis for meaningful discussions between providers and commissioners about the service and the lessons they are learning.

Instruments like MAP can compliment milestone management by providing a global picture of client change as the context for specific outcomes. They might also be used to measure those outcomes by means of (for example) changes in what for the service is the key MAP domain.

Demonstrating effectiveness requires perseverance and consistency from those commissioning and delivering services. Workable, valid techniques can can pay dividends by reassuring service users and the public that their investment in treatment for drug and alcohol problems is worthwhile.

1 Marsden J., Gossop M., Stewart D., *et al*. "The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome." *Addiction*: 1998, 93(12), p. 1857–1868. Copies of MAP from: National Addiction Centre, 4 Windsor Walk, London SE5 8AF

2 For example, which of MAP's domains are the most important for that service? What if clients improve in some domains but get worse on others?