Which outcome tool should you use?

Outcome monitoring must be made easy

Dear Editor

Outcome monitoring has been a theme in both (excellent) editions of FINDINGS.[1,2] Still it needs examining in more detail in the context of services without the luxury of the support of professional researchers.

A few years ago increased referrals to our community drug team led us to seek a formalised initial assessment tool which could later be used to gauge improvements. We examined three: EuropASI; the Maudsley Addiction Profile (MAP); and the Christo Inventory for Substance Misuse Services (CISS).

EuropASI is a European version of the US Addiction Severity Index. Completing this highly formalised questionnaire can take 45 minutes, but it is comprehensive and provides scores for several problem areas. The information summary is clear and priorities for action easily identified.

MAP is also multi-dimensional. It takes less time but we found it harder for a drug worker to interpret than EuropASI.

Both have their strengths, but for us they did not fit the bill. We are an open access service offering a range of interventions and operating to a three-day local standard for seeing new referrals. Over the five years we looked at these tools

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our client numbers doubled; last year new referrals were up by 43%. Staff increases have not kept pace with increased workload. We needed an efficient means to codify and standardise our assessment data, but the comprehensiveness of these tools was also their weakness: they take too long, their structure prevents clients unfolding how they see their problems at their own pace, and they can seem intrusive for an initial contact.

In response we started using **CISS** in September 1999. CISS is a simple, one page questionnaire which can deliver a single score. By February 2000 over 230 forms had been completed at initial assessment. It proved easy to administer and there has been a high degree of consistency between workers completing forms for the same client. The ease with which it can be built into everyday work with clients means CISS is now used as part of our quarterly reviews. Completed forms are held centrally so that at follow up workers are not tempted to allocate an improved score.

Unlike other tools, CISS does not require the client's presence. Most street agencies and community drug teams only know a client has been 'discharged' when they lose contact. They do not have the resources to follow them up, and for many it would be inappropriate to do so. Despite this, CISS allows initial assessment, review and discharge scores to be collected.

I can understand that purists will find fault with the simplicity of CISS, but that is its attraction for hard pressed staff. Outcome monitoring is essential, but until services have their own researchers or statistical support, the more complex measurement tools will fail to deliver what is urgently needed – a quick and easy method to indicate the initial severity of the problem and any subsequent changes. In the end what is important is to be able to demonstrate that there has been improvement since first contact.

Now CISS has been validated, any agency looking for an effective and efficient means of codifying client information should consider adopting it.

Paul Wells

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1 Ashton M. "NTORS." *Drug and Alcohol Findings*: 1999, 2, p. 16–22.
2 Gordon-Smith J, Christo G. "Are we right to spend more?" *Drug and Alcohol Findings*: 1999, 1, p. 26–27.

The toolmakers reply

CISS It is gratifying that Paul Wells has clearly identified CISS's purpose – a tool for those of us who work in busy services with no researchers and limited administrative support, where overworked staff have no time for forms, or already have tried and tested qualitative assessment interviews. It is for clients who may be uncooperative and stressful to work with, have reading difficulties, fail to turn up for assessments, discharge themselves without discharge interviews, or have their own agendas of things they want to tell you about.

In June 1999 FINDINGS was the first magazine to feature CISS. Since then the CISS validation study has passed peer review and will shortly be published in the international journal *Drug and Alcohol Dependence*.[1] CISS has also been featured in *Addiction Today* and *Druglink* and has rapidly grown in popularity; I have had about 200 requests for copies from across the UK.

The "purists" Paul refers to may be reassured that the pedigree of CISS is more than adequate. Its author has worked in this field for 15 years and holds doctorates in substance misuse treatment outcomes research and in clinical practice. The validation study basically showed that CISS is comprehensive, accurately measures what it is supposed to measure, and that different workers rating the same client will produce similar results – essential features of a useful instrument.[2]

If any other services want to try CISS, I will happily send them a copy with comparison scores.

George Christo

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1 Christo G, *et al.* "Validation of the Christo inventory for substance-misuse services (CISS): a simple outcome evaluation tool." *Drug and Alcohol Dependence*: in press, May 2000.
2 CISS's alpha internal consistency was 0.74; test-retest reliability 0.82; inter-rater reliability 0.82 and 0.91; discriminant validity 88% at a cut-off score of 6. Convergent validity is demonstrated by correlations of 0.43 to 0.99 with the Opiate Treatment Index and measures of trait anxiety, unpleasant life events, poor quality of life and low self-esteem.

LINKS
Issue 1, p. 26–27. CISS in practice.
Issue 1, p. 25–26. What commissioners want to know.
This issue, p. 21–23. Client follow-up at two alcohol services.
To come. MAP theory and practice.

MAP Outcome monitoring is hard work and requires a sustained commitment to gathering information – no one said it was going to be easy. That's why there are so few working systems across the world. Nevertheless, we're seeing a great surge of confidence in the UK about measuring outcomes on a day to day basis in treatment centres, and it's important for Paul and his staff team to have found a method which works for them and which they can use routinely.

As a researcher I make decisions about which questionnaires to use all the time, and use different ones for different purposes. Obviously, I think MAP is a good choice for treatment providers to make for outcome monitoring since we designed it with this in mind.

MAP records the core set of indicators used in outcome studies in our field, in a form everyone can readily understand and which can feed directly into the reporting of progress towards meeting the targets and goals of the UK's anti-drug strategy. It takes just 12 minutes to complete and was designed as a personal interview (although this could be over the phone), but self-completion by the client is an option we've tested and it works well.

I appreciate that busy centres will gravitate towards the least onerous way of collecting outcome information (ie, a proxy assessment from case notes) but I am not convinced that drug action teams and service commissioners will happily accept non-standard reporting. They want to know

Commissioners want to know concrete things – like 'How many fewer crimes were there?'

concrete things – like 'How many fewer crimes were committed by the clients?' Can Paul's service tell them that?

The real challenge is how to ensure that valid and reliable measurement of outcomes is a sustainable part of an agency's work and culture. That's why the new DAT-led schemes which enable services to feed in their forms for analysis are such an exciting development.

John Marsden

National Addiction Centre. For more on MAP visit the MAP web page or e-mail John Marsden using the link above