Matua Raki
National Addiction Workforce Development

Measuring recovery in adult community addiction services:

The testing and validation of ADOM Section 3 recovery questions

Te Pou
o Te Whakaaro Nui
Part of the Wise Group

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Evidence based workforce development

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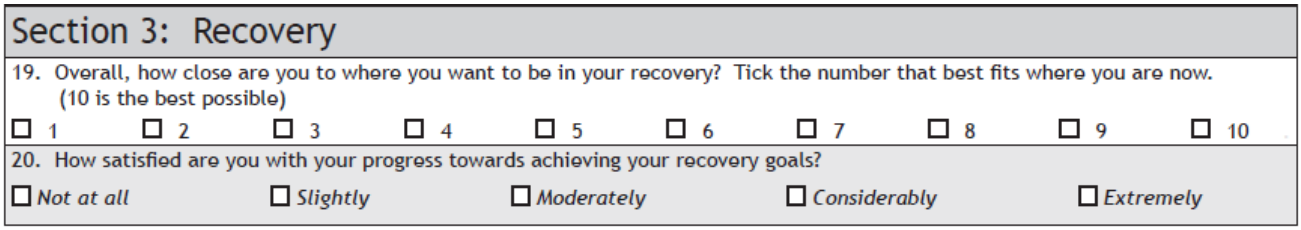
Background

Practitioners need accurate measures so the right decisions can be made about the course and efficacy of treatments (L. L. Cohen et al., 2008). The Alcohol and Drug Outcome Measure (ADOM) has been developed for the purposes of routine outcome measurement in alcohol and other drug (AOD) treatment services in New Zealand. The Ministry of Health has indicated they intend to mandate collection of the ADOM in the current Programme for the Integration of Mental Health Data (PRIMHD) from July 2015 in adult community-based (outpatient) addiction services. While use of Sections 1 and 2 of the ADOM, focused on AOD use and lifestyle and wellbeing, have been recommended for routine use across the AOD treatment sector (Deering et al., 2009; Galea, Websdell, & Galea-Singer, 2013), further work is needed to test and validate Section 3, focused on recovery.

Project aims

This project was undertaken to test and validate the two recovery questions included in Section 3 of the ADOM – Questions 19 and 20 (see Figure 1).



Section 3: Recovery

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

20. How satisfied are you with your progress towards achieving your recovery goals?

☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

Figure 1. Recovery questions 19 and 20 included in ADOM section 3.

The testing and validation process was informed by previous ADOM research, and minimum standards and guidelines for reviewing consumer-rated outcome measures. The main project aims were to investigate whether the recovery Questions 19 and 20 included in Section 3 of the ADOM:

- were acceptable to consumers
- were useful and feasible to administer in clinical practice
- had an acceptable level of convergent validity and sensitivity to change.

In addition, the acceptability of an alternative 5-point response scale was investigated as it could potentially improve the reliability of Question 19.

The project's results are expected to inform the Ministry of Health, be useful for those interested in evaluating the psychometric properties of the ADOM, and offer assurances to the AOD sector about the validity of the recovery questions included in the ADOM.

Method

The testing and validation process for Questions 19 and 20 involved four stages:

- Stage 1: an online survey of consumer leaders about the acceptability, including perceived usefulness
- Stage 2: an online survey of practitioners about the clinical utility, including the perceived usefulness and feasibility of administering in clinical practice
- Stage 3: analysis of de-identified consumer data collected in adult community-based (outpatient) addiction services to assess the acceptability, convergent validity, and sensitivity to change
- Stage 4: consultation with the Matua Raki Consumer Leadership Group on the project's draft findings and recommendations.

CareNZ and Northland District Health Board (DHB) participated in Stages 2 and 3. Both services have been voluntarily implementing the 20 item version of the ADOM and have data systems in place. Permission was sought to use de-identified data collected since March 2014.

Results

Feedback was provided by 14 consumer leaders and 11 clinicians. In total, data from 1,926 consumers in adult community-based (outpatient) addiction services was available for analysis from CareNZ and Northland DHB, which included 192 matched pairs between treatment entry and 6-week review.

All minimum evaluation criteria established a priori for Questions 19 and 20 were met as summarised in Table 1. The testing and validation process provides evidence to support the acceptability, convergent validity, sensitivity to change, and clinical utility of Questions 19 and 20. Evidence also indicates the current versions of both Questions 19 and 20 have a sufficient level of reliability following post hoc analyses. This suggests the use of an alternative response scale to Question 19 is not required.

Table 1. *Question 19 and 20 Results Compared with the Minimum Evaluation Criteria*

Test	Minimum evaluation criteria for Questions 19 & 20	Question 19	Question 20
Acceptability	Moderately acceptable and useful on average for thinking about recovery among consumer leaders	Yes	Yes
	Less than 10-15% missing data collected in clinical settings	Yes	Yes
Clinical utility	Moderately feasible to administer and useful on average for thinking about recovery amongst practitioners	Yes	Yes
Convergent validity	Statistically significant and negative relationships with ADOM indicators of mental and social wellbeing	Yes	Yes
	Statistically significant and positive large relationship with each other	Yes	Yes
Sensitivity to change	Significant mean differences in scores between treatment entry and 6-weeks	Yes	Yes

Recommendations

Key recommendations based on the project's findings are outlined below.

- Both Questions 19 and 20 should be considered for routine use as part of the ADOM in adult community-based (outpatient) addiction services in New Zealand as they meet minimum psychometric testing standards for a consumer-rated outcome measure
- Continue to use the 10-point response option to Question 19 within the ADOM. Several response options to Question 19 were investigated to potentially improve its reliability. While there was some preference for a 5-point verbal response option among consumer leaders, the 10-point response option to Question 19 currently used in the ADOM was found to have a sufficient level of inter-rater reliability and acceptability
- Undertake additional research examining the test-retest reliability, concurrent validity against more comprehensive recovery measures, and the generalisability of results to different populations and clinical settings to build a stronger evidence base. The psychometric properties of Questions 19 and 20 have been tested to a minimum acceptable level for routine clinical use.

Background

ADOM

The Alcohol and Drug Outcome Measure (ADOM) was developed by Deering and colleagues (Deering et al., 2009; Pulford et al., 2010) for the purposes of routine outcome measurement in the New Zealand alcohol and other drug (AOD) treatment sector. The original version of the ADOM was revised to include two questions focused on recovery following feedback from consumers and the Matua Raki ADOM Implementation Advisory Group. Table 2 contains a description of the ADOM and its psychometric properties. Attached in Appendix A is a copy of the measure and psychometric testing details.

Table 2. *ADOM Description and Characteristics*

Area	Details
Aims	The measure monitors changes in consumers' substance use, health and wellbeing, and recovery over time. It was intended for New Zealand AOD services and is most suitable for use in adult community-based (outpatient) addiction services where it can be collected over a period of time.
Content	The measure includes 20 items in three sections. Section 1 contains 11 relatively specific items assessing the type and frequency of substance use over the past four weeks. Section 2 includes seven items on the frequency of related lifestyle and wellbeing issues over the past four weeks. Section 2 includes questions related to physical and mental health, relationships, employment, housing, and criminal activity. Section 3 includes two items related to consumers' recovery and goal progression. Data is collected at the key clinical treatment stages of treatment entry, 6-week review, 3-month review, ongoing 3-month reviews, and treatment discharge.
User-centeredness	The ADOM is a consumer-rated outcome measure which is administered collaboratively by practitioners and the client or tangata whaiora. Development of the measure was informed by consumers, and sector representatives including Māori and Pacific peoples.
Psychometric properties	Section 1 has good test-retest reliability, concurrent validity when compared to other drug use measures, and excellent sensitivity to change. Following refinements, Section 2 has adequate inter-rater reliability and improved[1] concurrent validity when compared with other measures of psychosocial functioning, and satisfactory sensitivity to change. Further work is required to test the psychometric properties of Section 3.
Acceptability and feasibility	Items are acceptable to consumers and easy to follow. The measure has a good design. It is easy for practitioners to use and brief to administer. Several tools have been developed as a means of sharing a visual representation of consumers' progress including the Visual ADOM, ADOM Feedback Wheel, and the ADOM Graph Builder.

[1] Compared to the original ADOM questions.

Area	Details
Clinical utility	The measure is useful as a brief outcome tool for use with clients.[2] A small number of New Zealand AOD services have independently implemented the measure. Aggregate data has been used to evaluate the effectiveness of an intervention programme. Sections 1 and 2 of the ADOM have been recommended for routine use across AOD treatment services in New Zealand. The original version of the ADOM has been included as an outcome measure in contracts for residential AOD services providing beds for people requiring detox for methamphetamine use to report on to the Ministry of Health.
Other comments	The current version of the ADOM (ADOM Form Version 2) is freely available at http://www.matuaraki.org.nz
References	Deering, et al. (2009), Galea and Websdell (2011), Galea, et al. (2013), Pulford, et al. (2010), and Wheeler, Websdell, Galea, and Pulford (2011).

Routine use

The Ministry of Health has indicated they intend to mandate collection of the ADOM in the current Programme for the Integration of Mental Health Data (PRIMHD) from July 2015 in adult community-based (outpatient) addiction services. Following psychometric testing, Sections 1 and 2 of the ADOM have been recommended for routine use across the AOD treatment sector (Deering, et al., 2009; Galea, et al., 2013). However, further work is needed to test and validate Section 3 focused on consumers' recovery.

Recovery

There is a strong emphasis on a culture of recovery in the Ministry of Health's (2012) *Rising to the Challenge 2012-2017: Mental Health and Addiction Service Development Plan*. "Recovery" is a subjective term that means different things to different people. Personal recovery also differs from clinical recovery, which is primarily focused on symptom abatement and improved functioning (Mental Health Commission, 2011). The recovery process involves people gaining control over their substance use so they can maximise their health and wellbeing and fully participate in society (see UK Drug Policy Commission, 2008). One definition recently developed as part of the *Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce* describes recovery as "creating a meaningful self-directed life regardless of challenges faced, that includes building resilience, having aspirations and the achievement of these" (Te Pou., 2014b, p. 5).[3] While recovery is an individual process involving multiple pathways which takes place over time, common elements include relationships and support from others, hope and optimism about the future, building a positive identity, meaning in life, and personal responsibility and control (Davidson et al., 2008; Davidson & White, 2007; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). A key component of recovery-oriented service delivery therefore

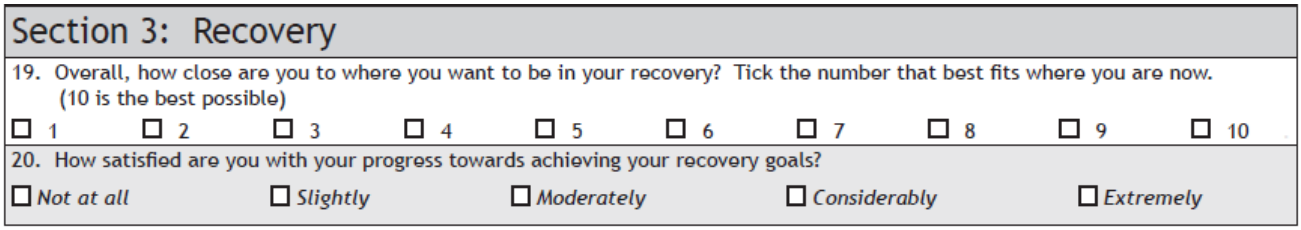
[2] The measure was designed as an outcome measure rather than an assessment tool.

[3] The Ministry of Health (2012, p. 73) has also described recovery as being "the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential". This definition is based on that developed by SAMHSA and a range of partners. See http://www.samhsa.gov

involves supporting consumers to strive towards personally valued goals, and reintegrate into society through genuine working relationships, and a commitment to recovery principles (Le Boutillier et al., 2011; Slade, 2012).

ADOM recovery questions

The original version of the ADOM was revised to introduce two recovery questions in Section 3 – Questions 19 and 20. The inclusion of Questions 19 and 20 in the ADOM was based on consumer feedback that a recovery question would be beneficial and consultation with sector representatives (Galea, et al., 2013).


Section 3: Recovery

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

20. How satisfied are you with your progress towards achieving your recovery goals?

☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

Figure 2. Recovery questions 19 and 20 included in ADOM section 3.

Question 19

Question 19 examines how close people are to where they want to be in their recovery (see Figure 2). Some testing of Question 19 has been undertaken in New Zealand. Galea and colleagues (2013) found consumers thought Question 19 was useful in measuring their recovery. They also examined the reliability of Section 2 of the ADOM by examining the extent to which eight clinicians agreed in their ratings of two vignettes of clinical scenarios. Their testing included Question 19, which was found to have a low but positive inter-rater reliability. Factors contributing to the low inter-rater reliability found by Galea et al. (2013) may include the level of training of clinicians in administering the ADOM, the absence of an anchor for response option one, and the ability of clinicians to discriminate between different response options (see Fitzpatrick, Davey, Buxton, & Jones, 1998; Hasson & Arnetz, 2005). Although this type of measure is generally more sensitive to small changes that occur,[4] the use of alternative response options (for example, a 5-point likert-type scale) may improve the psychometric properties of Question 19 and be more acceptable to consumers. Further testing is required to examine this, along with the validity and sensitivity to change of Question 19.

Question 20

Question 20 is concerned with the satisfaction of consumers in achieving their recovery goals (see Figure 2). Question 20 is derived from the Brief Addiction Monitor (BAM) developed in the US (Cacciola et al., 2013). Permission to use this item within the ADOM was sought from the author (D. Deering, personal communication, 2012). US research with veterans in outpatient and inpatient addiction programmes indicates Question 20 is acceptable to consumers, has excellent test-retest reliability, concurrent validity with quality of life measures, and is sensitive to change. Question 20 has also been proposed as a mental health quality indicator for use internationally to compare system performance across IIMHL participating countries (Pincus, Spaeth-

[4] For example, in comparison to likert-type scales.

Rublee, & Watkins, 2011). However, Question 20 has not been tested for use in New Zealand AOD treatment services.

Project purpose

This project aimed to test and validate the recovery Questions 19 and 20 included in Section 3 of the ADOM. While a good outcome measure is reliable (produces reproducible results), valid (measures what it claims to measure), and sensitive to change (can detect changes over time due to treatment that matter to consumers), usability is also critical if a tool is to have value in clinical settings (see Fitzpatrick, et al., 1998; Greenhalgh, Long, Brettle, & Grant, 1998; Ion, Monger, Hardie, Henderson, & Cumming, 2013). Therefore, the assessment of consumer-based outcome measures should consider the instruments' appropriateness and feasibility for use in clinical practice, and the acceptability of questions to consumers (see Fitzpatrick, et al., 1998). After taking into account prior testing of Sections 1 and 2 of the ADOM, guidelines for the selection of consumer-rated outcome measures, and minimum standards for testing measures (see Appendices A and B), the main research questions included whether Questions 19 and 20 included in Section 3 of the ADOM:

- were acceptable to consumers
- were useful and feasible to administer in clinical practice
- had an acceptable level of convergent validity and sensitivity to change.

In addition, the acceptability of Question 19 rated on a 5-point likert scale was examined as it could potentially improve its reliability.

Method

Procedure

The testing and validation process of Questions 19 and 20 included in Section 3 of the ADOM involved four stages as illustrated in Figure 3. Testing was undertaken between September and November 2014.

Stage 1	Stage 2	Stage 3	Stage 4
Consumer leaders' feedback on question acceptability, including perceived usefulness	Practitioner's feedback on the perceived usefulness and feasibility of administering questions in clinical practice	Analysis of de-identified consumer data to assess acceptability, convergent validity and sensitivity to change	Consultation with Matua Raki Consumer Leadership Group on draft findings and recommendations

Figure 3. Stages of testing and validation.

Stage 1: Consumer leaders' feedback

From the outset, development of the ADOM has involved consumer input. It is important that outcome measures incorporate questions that matter to consumers and their acceptability is assessed in the early stages of questionnaire design (Fitzpatrick, et al., 1998). In September 2014, consumer leaders, advisors, peer support workers and other consumer representatives were invited to complete a brief online survey via the Matua Raki Consumer Leadership Group. The survey examined the acceptability and usefulness of the tool for measuring consumers' recovery progress during treatment, as well as preferred response options for Question 19, expected changes in recovery over different time periods, and any recommended changes (see Appendix C). The project aimed to recruit at least 10-12 people working in designated consumer roles.

Stage 2: Practitioner's feedback

Earlier work has identified the importance of gaining clinician 'buy-in' in the implementation and routine use of outcome measures (see Wheeler, et al., 2011). Practitioners from CareNZ and Northland DHB were invited to take part in Stage 2. Each service was asked to distribute an invitation to their practitioners to complete an online survey in November 2014.[5] Practitioners were asked how useful the recovery questions were in clinical practice, how practical they were to administer, what changes in recovery they expected over different time periods, and their preferred response options for Question 19 (see Appendix D). The project aimed to recruit at least 10-12 practitioners working in a range of professional roles, such as psychiatrists, medical officers, nurses, and allied health professionals.

Prior to completing the online surveys, both consumer leaders and practitioners were provided information about the study. Consent to take part was implied by survey completion. Participants were also advised they could request a summary copy of the project's findings once they were available.

[5] The services chose which clinicians they sent it to due to practical time constraints.

Stage 3: Data analysis

Stage 3 involved the analysis of de-identified consumer data collected by CareNZ and Northland DHB. These services have been voluntarily implementing the 20 item version of the ADOM since at least March 2014, and have data systems in place. These services also reflect a variety of different adult community-based (outpatient) addiction services in New Zealand, in which the collection of the ADOM is most appropriate (for example, opioid substitution treatment [OST], joint AOD and mental health service, rural satellite services, and include services with a large Māori population base).[6] Permission to use de-identified data was obtained in writing. Data from CareNZ and Northland DHB was used to examine the acceptability of the recovery questions, convergent validity, and sensitivity to change.

Stage 4: Matua Raki Consumer Leadership Group

The Matua Raki Consumer Leadership Group was consulted in November 2014 on the study's draft findings and recommendations for implementation of Section 3 of the ADOM across adult community-based (outpatient) addiction services. The Matua Raki Consumer Leadership Group provides strategic direction and support to Matua Raki and includes people with expertise in the addiction treatment sector, consumer experience, and networks with the wider consumer workforce including mental health, peer support, Māori, and Pacific.

Analysis

Data screening and missing data

All data was screened prior to analysis. Archival data with more than 25 per cent of responses missing were deleted from further analysis. In total, 269 cases with more than 25 per cent of missing data were deleted, of which 237 (88 per cent) were at treatment end (for example, did not attend [DNA]). Following deletion, 1,926 cases were available for analysis. All other missing data was coded as 99. In matched pair analyses, scores between four and eight weeks were included in the 6-week review data, leaving 192 cases for analysis. All other data was within the acceptable range. Ethnicity data from one organisation was prioritised so that New Zealand Europeans and other ethnicities that also identified as Māori or Pacific were coded as the latter.[7] Northland DHB had a greater proportion of Māori and less Pacific peoples than CareNZ. However, the results for each provider were combined given preliminary analyses yielded similar results.

Acceptability

To assess the acceptability of Questions 19 and 20, consumer leaders were asked whether they understood the recovery questions, whether the questions were easy to answer, and whether they would be willing to answer them. Each question was rated on a 4-point scale ranging from 1 (*disagree*) to 4 (*strongly agree*) (see page 50).

[6] The types of services that can be examined at this stage were limited by those who have voluntarily chosen to implement the ADOM. As collection will be mandated from 2015 this is expected to change.

[7] The other organisation provided prioritised ethnicity data.

Three questions were used to ask consumer leaders about the perceived usefulness of the recovery questions. These included whether the questions were useful for facilitating dialogue and discussion, monitoring consumers' recovery progress, and indicating whether consumers had benefitted from treatment. Each question was rated on a 4-point scale ranging from 1 (*not at all*) to 4 (*very useful*) (see page 50).

Average scale scores were calculated to assess the overall acceptability and perceived usefulness of Questions 19 and 20 to consumer leaders. Open ended feedback was analysed to identify key themes that emerged. Item response rates and the proportion of missing data in response to Questions 19 and 20 were also calculated. Response rates are one of the most direct and easiest methods of assessing the acceptability of questionnaire items (Fitzpatrick, et al., 1998).

Clinical utility

To assess the feasibility of administering Questions 19 and 20 in clinical practice, practitioners were asked whether they understood each question, they seemed easy for clients to answer, and felt comfortable asking clients to complete these (see page 56). Each item was rated on a 4-point scale ranging from 1 (*disagree*) to 4 (*strongly agree*). Practitioners were asked similar questions as consumer leaders to assess the perceived usefulness of Questions 19 and 20 (see page 56). Average scale scores were calculated to assess the overall feasibility and perceived usefulness of Questions 19 and 20 in clinical practice. Open ended feedback was analysed to identify key themes that emerged.

Convergent validity

Data from CareNZ and Northland DHB was used to examine the convergent validity, which is a type of construct validity.[8] The convergent validity was assessed by examining the correlation coefficients (*r*) between the recovery items in the ADOM with those focused specifically on mental and social wellbeing included in Section 2 of the measure. The importance of these factors has been highlighted in conceptual models of recovery in addictions and mental health (Davidson, et al., 2008; Davidson & White, 2007; Leamy, et al., 2011). The recovery questions were expected to have negative and moderate relationships with mental and social wellbeing indicators based on previous research (Dennis, Scott, Funk, & Foss, 2005; McNaught, Caputi, Oades, & Deane, 2007; Nelson, Young, & Chapman, 2014; Salzer & Brusilovskiy, 2014). To test the convergent validity, the relationship between Questions 19 and 20 was also examined. Items assessing similar constructs are expected to have a stronger relationship with each other than other items assessing other constructs (see Fitzpatrick, et al., 1998). A strong and positive relationship between Questions 19 and 20 was expected. Data from at least 85 consumers was required to have sufficient statistical power to detect moderate relationships (see J. Cohen, 1992). Scores were interpreted using the guidelines in Table 3.

[8] "Criterion validity is assessment when an instrument correlates with another instrument or measure that is regarded as a more accurate or criterion variable… in the absence of a criterion variable [for example, a 'gold standard' measure], validity testing takes the form of construct validation" (Patient Reported Outcomes Group, n.d.).

Table 3. *Guidelines for Interpreting Results*

Analysis	Statistic	Guidelines
Convergent validity	Correlation coefficient	r = .10, .30 and .50 reflect small, medium and large relationships respectively
Sensitivity to change	Effect size	d = 0.20, 0.50, and 0.80 reflect small, medium and large effect sizes respectively
Source: J. Cohen (1992)		

Sensitivity to change

Sensitivity to change, or the ability to detect meaningful change over time due to treatment, was assessed using data from one organisation.[9] Mean scores at treatment entry were compared with those at 6-week follow-up (+/- 2 weeks). While a longer time period would allow for greater changes to be detected, the analyses were restricted by available data. Paired samples t-tests were conducted and the effect size was calculated using Cohens *d*.[10] Matched pair data collections from at least 64 consumers at treatment entry and follow-up were required to detect moderate mean differences (see J. Cohen, 1992). Results were interpreted using the guidelines presented in Table 3.

Reliability

To potentially improve the reliability of Question 19, consumer leaders and practitioners were asked which response option(s) to Question 19 they preferred. Consumer leaders and practitioners were asked about their preference for the 10-point numerical scale currently used in the ADOM (option 1), and an alternative 5-point *verbal* response scale (option 2). Consumer leaders were also given the option of selecting a 5-point *numerical* response scale, but as no one chose this, it was not tested with practitioners. Descriptive statistics were used to identify the preferred response option to Question 19. Key themes emerging from open ended feedback were also identified.

Software

The consumer leaders' and practitioner's online surveys were administered and analysed using SurveyMonkey. Analyses of CareNZ and Northland DHB's data were performed using SPSS version 22 using listwise deletion.

[9] No matched pairs data was available for the other organisation. Prior to conducting sensitivity to change analyses, insights were gained about expected changes in recovery scores over different time periods by gathering feedback from clinicians and consumer leaders. Small changes were expected initially, followed by greater changes over longer time periods.

[10] There is no single agreed method for assessing sensitivity to change (Patient Reported Outcomes Group, n.d.).

Minimum evaluation criteria

Findings were compared against the minimum criteria established a priori as outlined in Table 4 for determining whether Questions 19 and 20 would be recommended to the Ministry of Health for routine use in adult community-based (outpatient) addiction services.

Table 4. *Minimum Evaluation Criteria*

Issue	Data source	Criteria
Acceptability	Consumer leaders' feedback	Overall, the item is at least moderately acceptable and useful on average for thinking about consumers' recovery
	Archival data	The item has less than 10-15% missing data collected in clinical settings
Clinical utility	Practitioner's feedback	Overall, the item is at least moderately feasible to administer on average in clinical practice, and is perceived as useful and relevant for thinking about consumers' recovery
Convergent validity	Archival data	The item has statistically significant and negative relationships with indicators of mental and social wellbeing in Section 2 of the ADOM
	Archival data	Questions 19 and 20 have a statistically significant and positive large relationship with each other
Sensitivity to change	Archival data	Significant mean differences between treatment entry and 6-week review are detected

Ethics

As the project did not involve the collection of data directly from consumers and had a low risk of harm, the Northern Health and Disability Ethics Committee advised in August 2014 that formal ethical approval was not required.

Results

Participants

Consumer leaders and practitioners

Online surveys (see Appendices C and D for details) were completed by:

- 14 consumer leaders (including at least two Māori and four New Zealand Europeans)
- 11 practitioners (10 New Zealand Europeans/Other, one Pasifika; four males and seven females).[11]

Archival data

Data from 1,926 consumers from CareNZ and Northland DHB were available for analysis; 1,260 at treatment start, 262 at 6-week review, 52 at 3-month review, and 158 at treatment end. In total, there were 192 matched pairs between treatment entry and 6-week review available for analysis from one organisation. As summarised in Table 5, over two-thirds of consumers were males and one-third Māori. The average age of consumers was 36.3 years (*SD*=11.7; range 16-78).

Table 5. *Demographic Characteristics of Consumers at Treatment Entry, N=1,260*

Characteristic	Details	Number	Percentage
Gender	Male	1,377	71%
	Female	544	28%
	Transgender	5	<1%
Ethnicity*	Māori	413	33%
	Pacific	161	13%
	NZ European/Other	686	54%

Note. *Prioritised ethnicity.
Data source: CareNZ and Northland DHB. Te Pou calculations.

Tables 6 and 7 summarise AOD use at treatment entry, and lifestyle and wellbeing factors collected through Sections 1 and 2 of the ADOM. Consumers were most likely to report using alcohol or cannabis, and problems with work, study or caregiving. Approximately 7 in 10 consumers also smoked.

[11] Participants were asked if they were clinicians working in the AOD sector; information on professions was not captured.

Table 6. *AOD Use at Treatment Entry During the Past Month, N=1,260*

Type of AOD	Number	Percentage
Alcohol	845	75%
Cannabis	357	32%
Amphetamine-type stimulants	126	11%
Opioids	37	3%
Sedatives/tranquilisers	51	5%
Cigarettes	771	68%
Note. Data source: CareNZ and Northland DHB. Te Pou calculations.		

Table 7. *Lifestyle and Wellbeing Indicators at Treatment Entry, N=1,260*

Indicator*	Mean	*SD*
General physical health problems	2.1	1.5
General mental health problems	2.3	1.5
Problems or arguments with friends or family	1.8	1.2
Problems with work or other activities	1.8	1.2
Engagement with work, study, and caregiving activities	3.6	1.7
Housing difficulties	1.3	1.0
Involvement in criminal or illegal activity	1.3	0.8
Note. *Lifestyle and wellbeing questions are rated on a 5-point scale ranging from 1=not at all, 2=less than weekly, 3=once or twice a week, 4=three or four times a week, to 5=daily or almost daily. *SD* = standard deviation. Data source: CareNZ and Northland DHB. Te Pou calculations.		

Acceptability

Item response rates and feedback from consumer leaders were used to assess the acceptability of Questions 19 and 20.

Response rates

Based on data from CareNZ and Northland DHB, the number of consumers who had answered Questions 19 and 20 in the ADOM is presented in Table 8. Both Questions 19 and 20 had less than five per cent missing data.

Table 8. *Response Rates for Question 19 and 20, N=1,926*

Question	Number respondents	Number missing data	Response rate %	Missing data %
Question 19	1,880	46	97.6%	2.4%
Question 20	1,865	61	96.8%	3.2%
Note. Data Source: CareNZ and Northland DHB. Te Pou calculations.				

Consumer leaders' feedback

Acceptability

Overall, both Questions 19 and 20 were at least moderately acceptable to consumer leaders on average (see Figure 4). While consumer leaders at least moderately agreed that they understood both Questions 19 and 20, and would be willing to answer these questions, the perceived ease in which these questions could be answered was slightly lower. Open ended feedback highlighted how recovery means different things to different people. That is, people have different interpretations and understandings of recovery, and different goals.[12] Recovery was also described as an ongoing personal process in which goals were expected to change. For example, "recovery is a journey not a destination", "[it] does not go in a straight line", "recovery is [not] an event… recovery is a process and changes and grows and waxes and wanes". Consumer leaders also commented on several factors that may influence recovery ratings including negative events, one's mood, and self-perceptions.

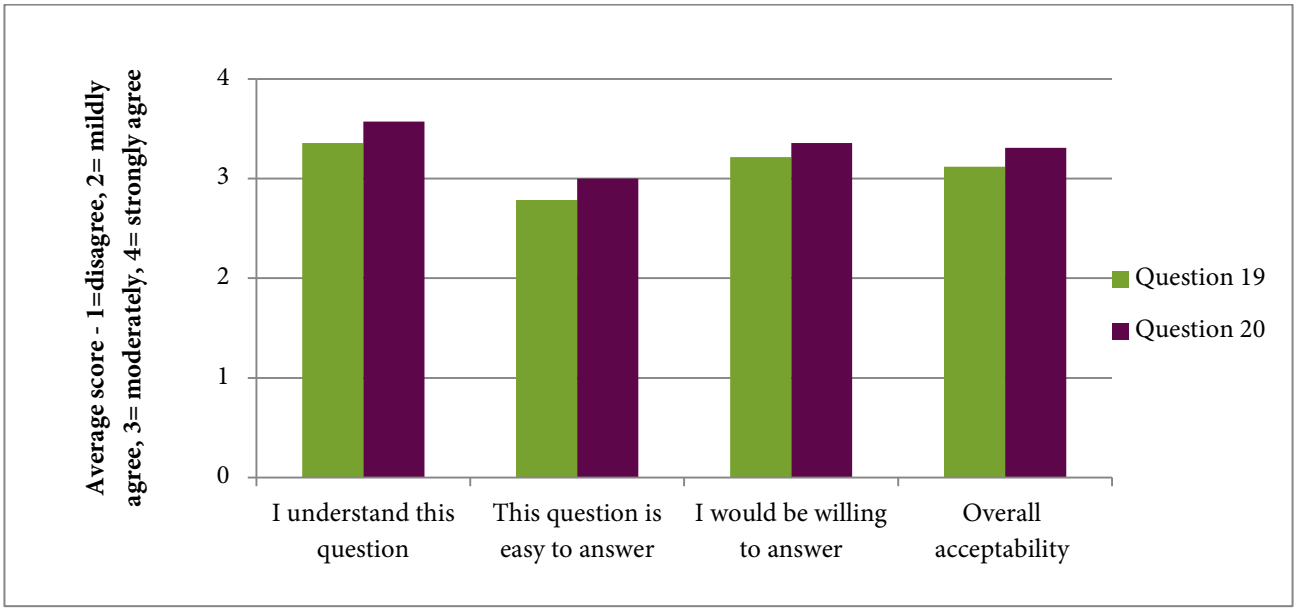


Figure 4. Acceptability of questions 19 and 20 amongst 14 consumer leaders.

[12] They may also have different short and long-term goals.

Perceived usefulness

When asked about the perceived usefulness of Questions 19 and 20, on average consumer leaders thought they were at least moderately useful for facilitating dialogue and discussion, and for monitoring consumers' recovery progress. Open ended feedback also suggested Questions 19 and 20 were particularly useful for stimulating conversations with consumers about their recovery, developing a better understanding of individual recovery and goals, and reflection by consumers who can be relatively self-critical. The perceived usefulness of Questions 19 and 20 for assessing whether consumers had benefitted from treatment was slightly lower. Open ended feedback highlighted a range of factors that may influence recovery, including peer support (formal and informal), individual motivation, and other external factors and events. Nevertheless, overall both Questions 19 and 20 were perceived as at least moderately useful on average by consumer leaders (see Figure 5).

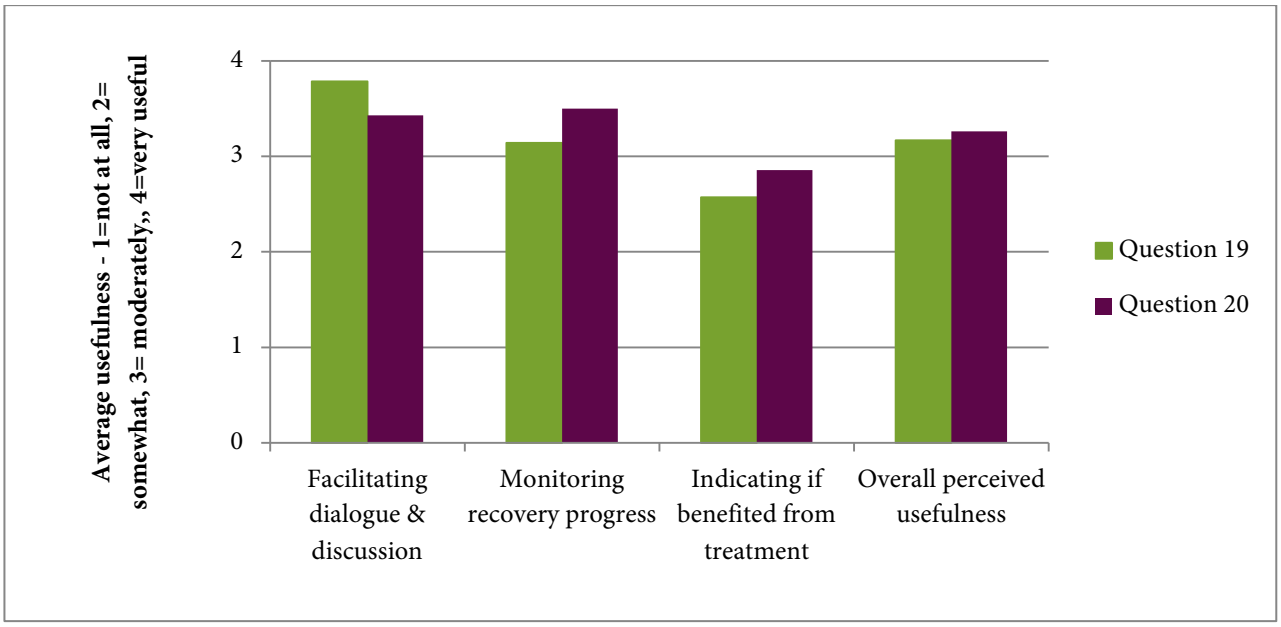


Figure 5. Perceived usefulness of questions 19 and 20 amongst 14 consumer leaders.

Clinical utility

Feasibility

Practitioners moderately agreed on average that it was feasible to administer Questions 19 and 20 in clinical practice (see Figure 6). Practitioners at least moderately agreed that they understood the recovery questions and felt comfortable asking clients to complete them. The perceived ease in which clients could complete Questions 19 and 20 was rated slightly lower by practitioners. Feedback suggested that in some contexts and with some population groups it was often more challenging for clients to answer the questions due to factors such as understanding, insights and motivation.[13] Practitioners who perceived Questions 19 and 20 as being more difficult for clients to answer also tended to be less comfortable asking clients to complete these questions.

[13] For example, mandated probation clients and where English is a second language.

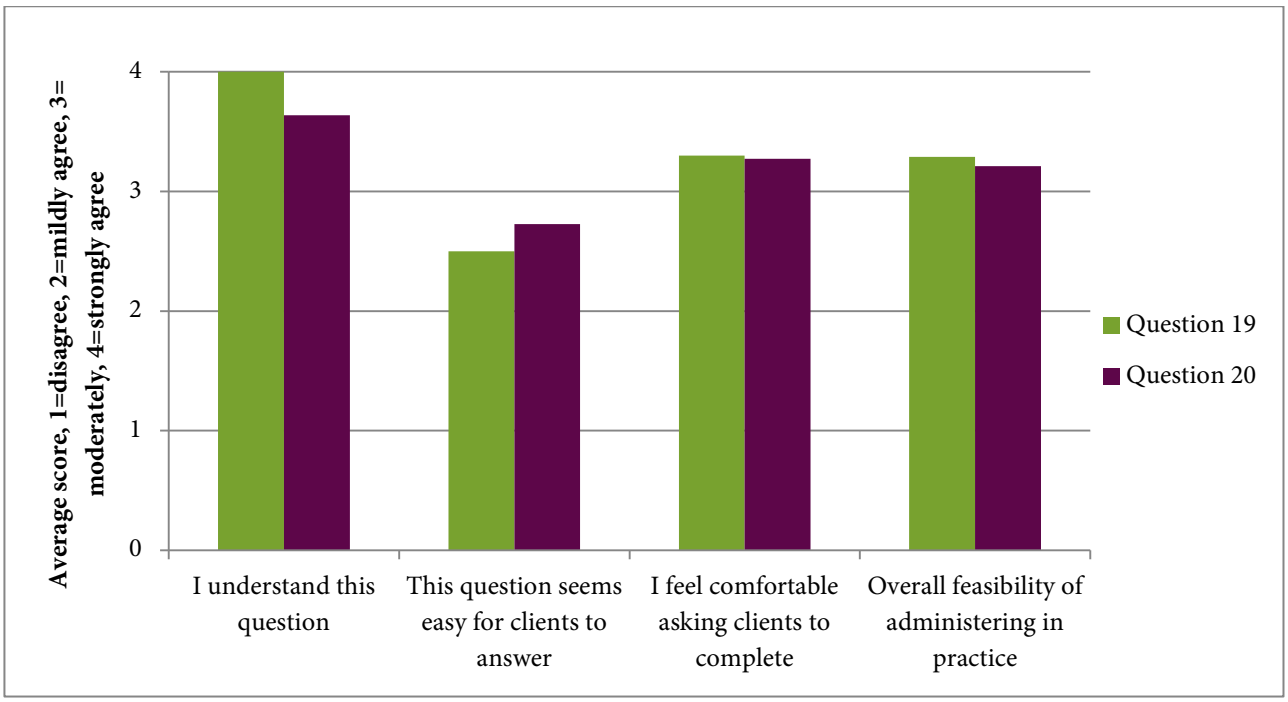


Figure 6. Feasibility of administering questions 19 and 20 in clinical practice amongst 11 practitioners**.**

Perceived usefulness

Questions 19 and 20 were rated moderately useful on average (see Figure 7) based on their potential to facilitate dialogue and discussion, monitor clients' recovery progress, and indicate whether clients had benefitted from treatment or not. Open ended feedback indicated the questions were particularly useful for facilitating discussion about the meaning of recovery for different people, looking at individual recovery goals, and for clients to reflect on their recovery journey. The recovery questions were also seen as useful for creating a sense of hope. Practitioners noted how client expectations, ideas and goals of recovery change over time as they improve. Recovery was also seen as being influenced by a range of factors, including coexisting issues, the length of time behaviour patterns have existed, and the level of social support to make changes.

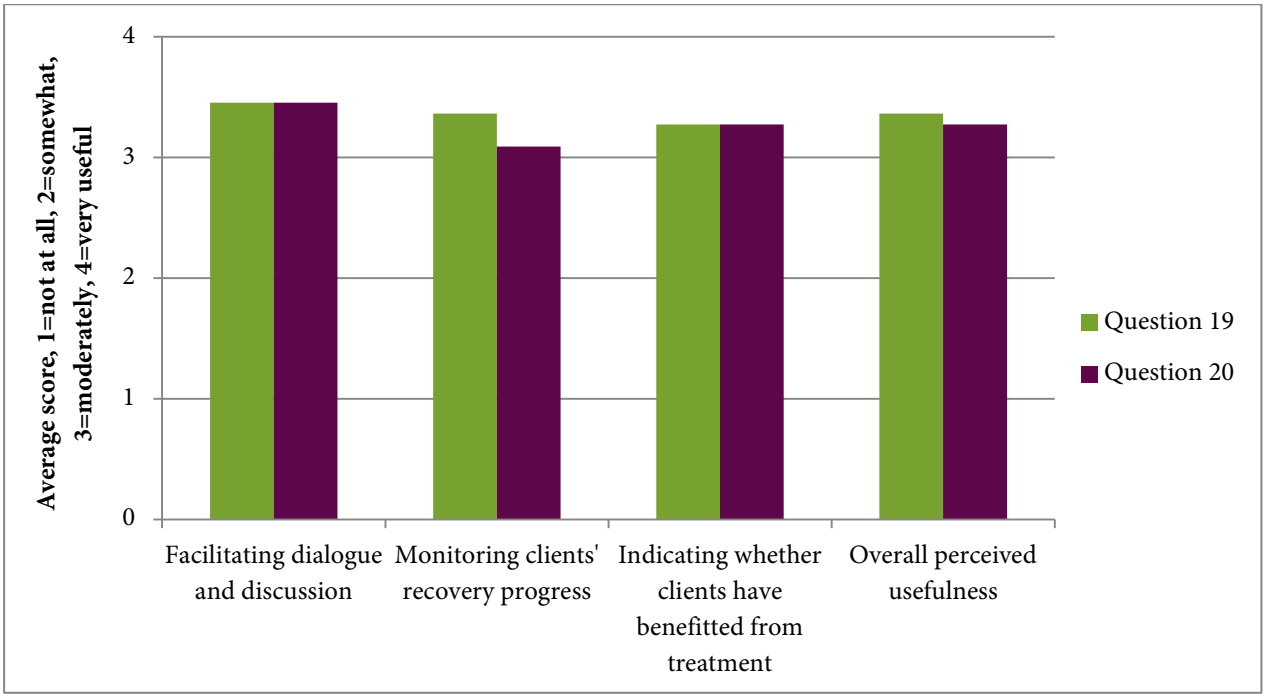


Figure 7. Perceived usefulness of questions 19 and 20 amongst 11 practitioners.

Convergent validity

Table 9 indicates that both Questions 19 and 20 have a negative and moderate relationship with indicators of mental and social wellbeing at treatment entry (r = -.33 to -.45). Similar relationships were detected using 6-week review data. Table 9 also shows Questions 19 and 20 have a large and positive relationship with each other (r = .67).

Table 9. *Correlation Between Questions 19 and 20, and Mental and Social Wellbeing Indicators at Treatment Entry, N=1,260*

Question	Q19	Q20
Q13 General mental health problems	-.45*	-.38*
Q14 Problems or arguments with friends and family members	-.44*	-.33*
Q15 Problems with work or other activities	-.42*	-.34*
Q19 How close to where you want to be in your recovery	-	.67*
Q20 Satisfaction with progress towards achieving recovery goals	-	-

Sensitivity to change

Figures 8 and 9 illustrate the distribution of scores on Questions 19 and 20 at treatment start and 6-week followup. The change in individual scores on Questions 19 and 20 between treatment entry and 6-week followup are illustrated in Figures 10 and 11.[14]

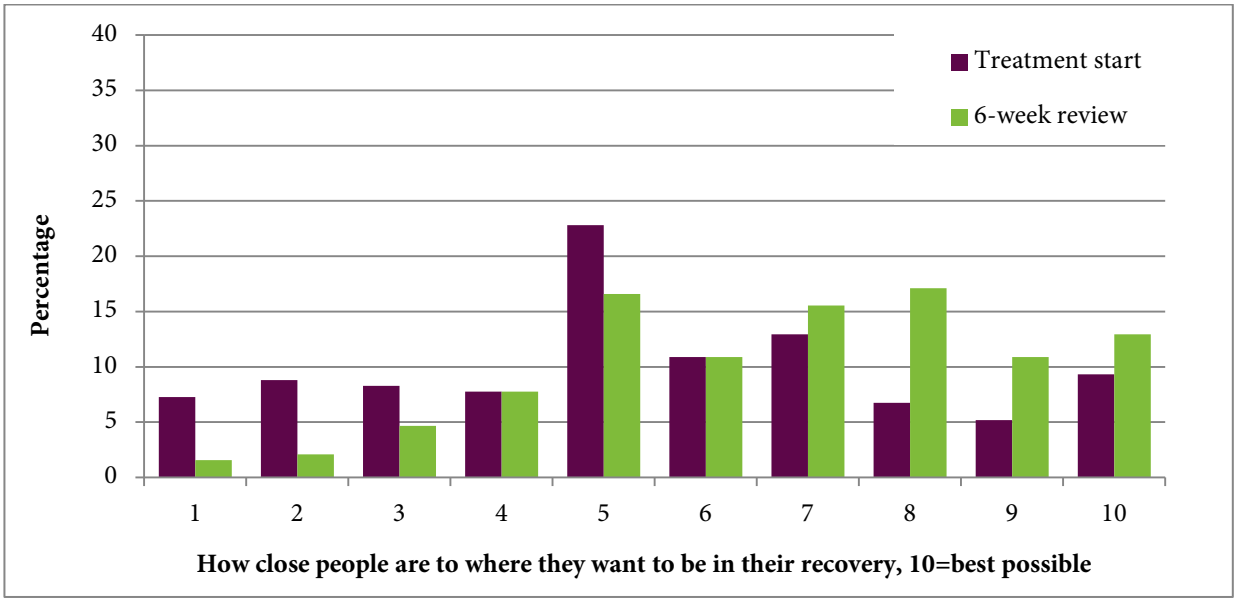


Figure 8. Scores at treatment start and 6-week followup on Question 19 for 192 consumers.

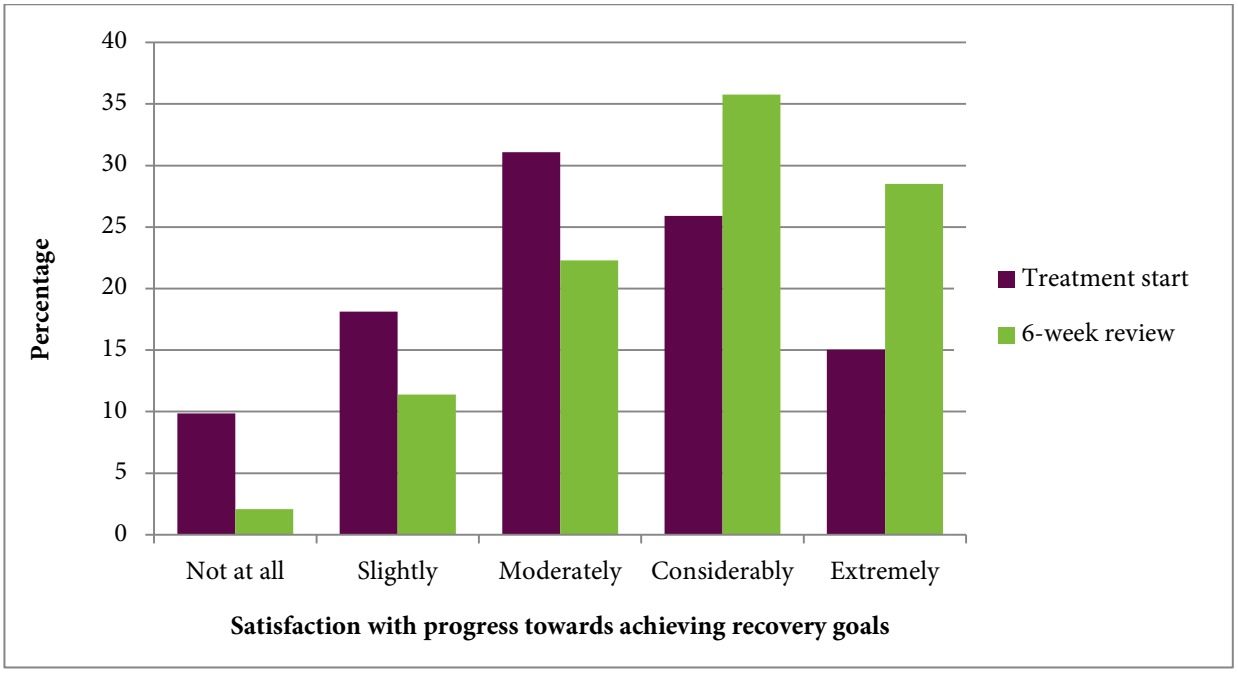


Figure 9. Scores at treatment start and 6-week followup on Question 20 for 192 consumers.

[14] Based on calculations of 6-week review scores – treatment start.

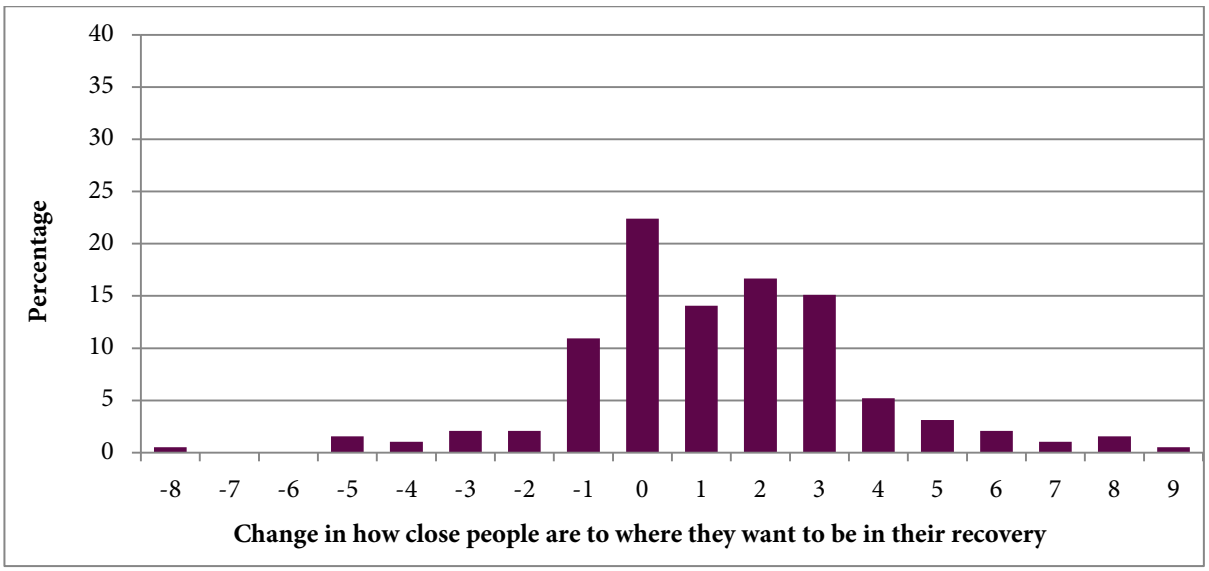


Figure 10. Change in individual scores between treatment start and 6-week followup on Question 19 for 192 consumers.

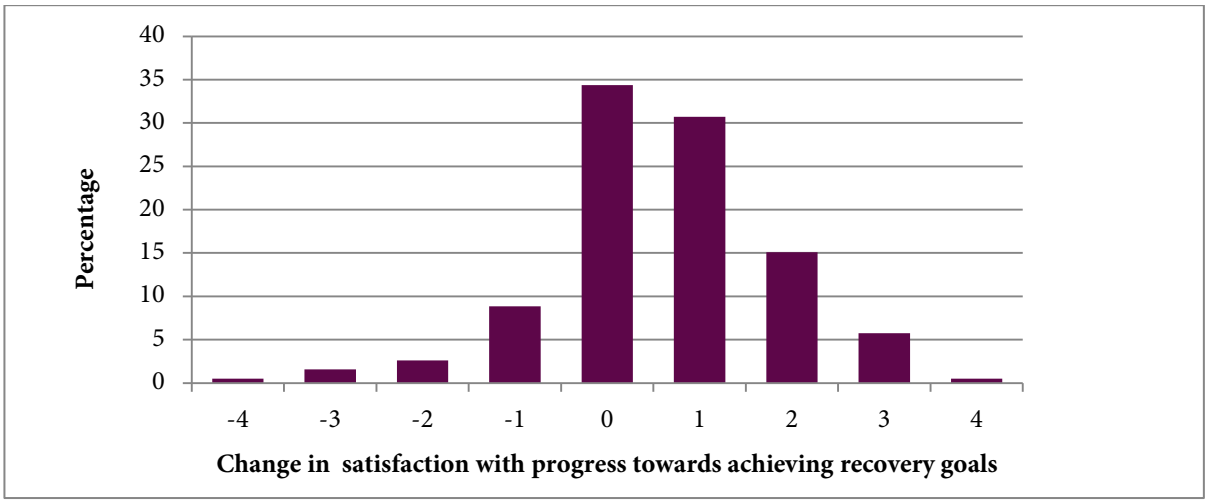


Figure 11. Change in individual scores between treatment start and 6-week followup on Question 20 for 192 consumers.

Between treatment entry and 6-week review, significant mean differences on Questions 19 and 20 were detected. As summarised in Table 10, on average recovery ratings on Questions 19 and 20 were moderately higher at 6-weeks compared with treatment entry.[15]

[15] Based on Cohen's guidelines in Table 3 (page 17).

Table 10. *Sensitivity to Change of Question 19 and 20 Between Treatment Start and 6-week Followup, N=192*

Question	Treatment start Mean (*SD*)	6-week follow-up Mean (*SD*)	*t**	Effect size *d*
Question 19	5.5 (2.6)	6.7 (2.2)	7.21	0.53
Question 20	3.2 (1.2)	3.8 (1.1)	6.54	0.53
Note. *p<.001. *SD* = Standard deviation.				

Reliability

To potentially improve the reliability of Question 19, consumer leaders were asked which response option(s) to Question 19 they preferred (see Figure 12 for details). Figure 13 shows that 8 out of 14 people preferred a 5-point likert-type *verbal* response scale (option 2), and 5 people preferred the 10-point numerical response scale currently used in the ADOM (option 1). Consumer leaders were also given the option of selecting an additional 5-point *numerical* response scale. As no one chose this option, no further testing of this was undertaken with practitioners.

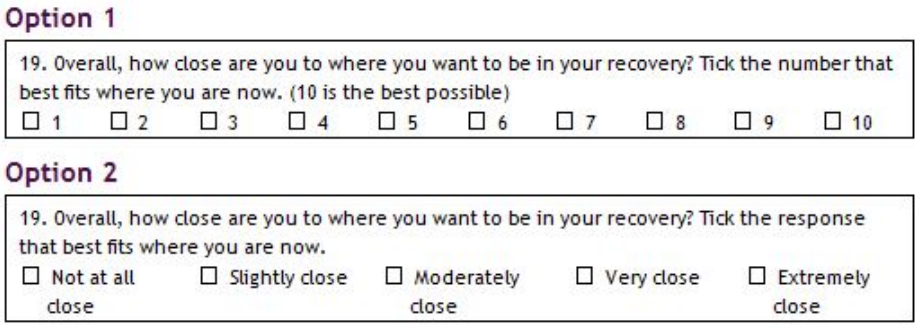


Figure 12. Question 19 possible response options.

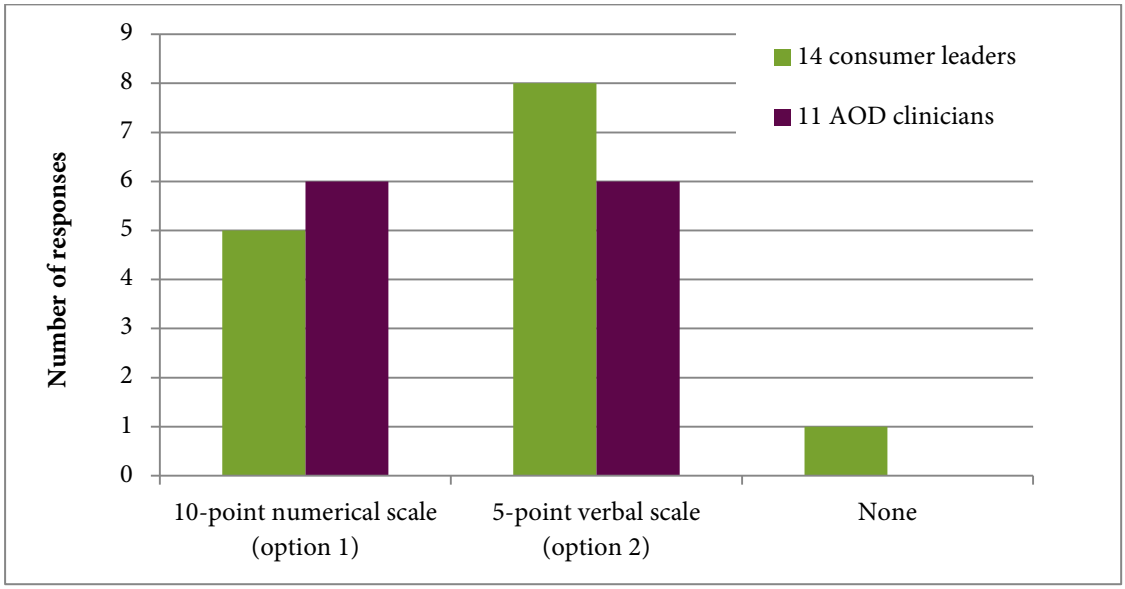


Figure 13. Preferred response option to question 19 amongst consumer leaders and practitioners.

Practitioner's preferences were split 50:50 between option 1 and 2. Open ended feedback from practitioners indicated the use of numbers was useful for charting clients' progress, and verbal response scales were more subjective. Practitioners also suggested that Question 20 with a verbal response scale was more difficult for clients to answer, and the use of numbers usually made completion easier.

Conversely, feedback from consumer leaders suggested the inclusion of words in the response scale made Question 19 clearer and simpler. Some people still preferred a 10-point response scale as it gave consumers more options to choose from. Others thought Question 19 was problematic (for example, influenced by one's mood or other issues) and suggested other questions.

Other feedback

When consumer leaders were asked specifically about other recovery questions they would recommend including in the ADOM, feedback included:

- individual goals, ambitions and hope (for example, "what is it you want to get out of recovery?", "where do you wish to be and how you plan to achieve this?")
- individual experiences of recovery (for example, "how would you see your journey?", "what's happening in your life?", "how does recovery feel?", and "have you relapsed?")
- learnings (for example, "what tools did you learn to support your life out of treatment?", "what are your learnings from your recovery?")
- other supports required (for example, "what supports and resources are needed?")
- the role of services in supporting recovery (for example, "has the service you've received helped you towards your recovery?").

Consultation with Consumer leaders

Te Pou consulted with the Matua Raki Consumer Leadership Group over the draft findings and recommendations. This was done through their November 2014 meeting in Christchurch. Based on the evidence presented, the members of the group agreed that Questions 19 and 20:

- were acceptable to consumers
- were useful and feasible to administer in clinical practice
- had an acceptable level of convergent validity and sensitivity to change.

Feedback on the preferred response option to Question 19 was not sought due to the information available at this stage. Nevertheless, post hoc analyses indicated Question 19 had a sufficient level of reliability and that revision of the response scale was not necessary.

The consumer leaders consulted in Stage 4 of this project strongly supported the draft recommendations for adopting Questions 19 and 20 into routine clinical practice. They thought the use of the two recovery questions would assist consumers in their recovery.

Discussion

The project's key aims were to investigate whether the recovery Questions 19 and 20 included in Section 3 of the ADOM:

- were acceptable to consumers
- were useful and feasible to administer in clinical practice
- had an acceptable level of convergent validity and sensitivity to change.

The acceptability of Question 19 rated on a 5-point response scale was also investigated to potentially improve its reliability.

Acceptability and clinical utility

Client-based outcome measures should be acceptable to consumers and have clinical utility (see Fitzpatrick, et al., 1998). Earlier research provides some evidence to support consumers' acceptability of the recovery questions included in the ADOM (see Cacciola, et al., 2013; Galea, et al., 2013). The low proportion of missing data found on Questions 19 and 20 provides further evidence indicating Questions 19 and 20 are acceptable to consumers. In addition, consumer leaders indicated that they understood Questions 19 and 20, the questions were easy to answer, and they would be willing to answer these questions. When practitioners were asked similar questions, they also indicated that Questions 19 and 20 were feasible to administer in clinical practice.[16] As shown in Figure 14, there was a high level of agreement between consumer leaders' and practitioner's ratings of the acceptability and feasibility of Questions 19 and 20.

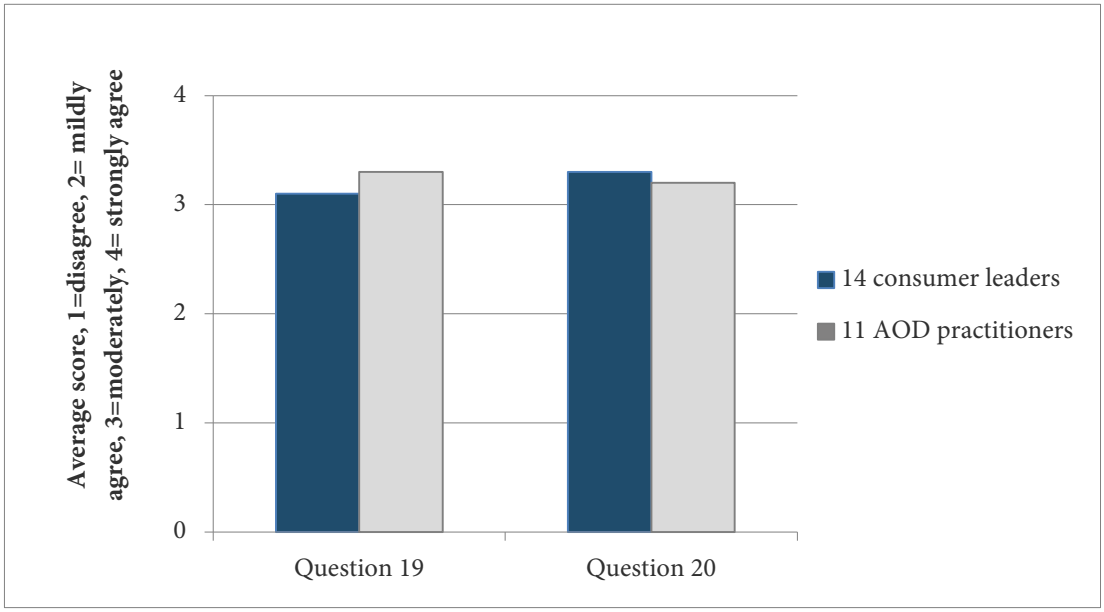


Figure 14. Acceptability to consumer leaders and feasibility of administering questions 19 and 20 amongst practitioners.

[16] Clinicians were asked about their understanding of the questions, the perceived ease for clients to answer, and how comfortable they felt administering Questions 19 and 20.

Both consumer leaders and practitioners perceived Questions 19 and 20 to be useful in clinical practice (see Figure 15). The ability of Questions 19 and 20 to facilitate dialogue and discussion was seen as the greatest benefit. Feedback also indicates that the process of measurement can help facilitate recovery by generating hope and optimism, and is strengthened where there is support from others. Overall, both Questions 19 and 20 meet the minimum evaluation criteria set a priori for acceptability and clinical utility.

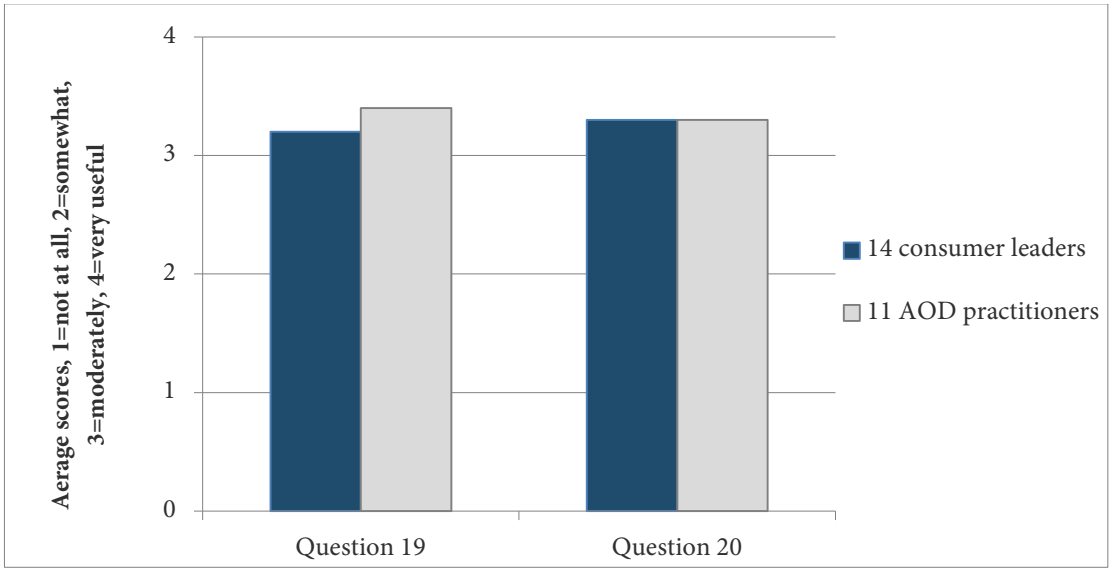


Figure 15. Perceived usefulness of questions 19 and 20 amongst consumer leaders and practitioners.

Validity

Validity is a key psychometric property and can be assessed using a variety of strategies. Tests of convergent validity were undertaken and indicate Questions 19 and 20 are related to indicators of mental and social wellbeing.[17] These findings were expected based on models of personal recovery (see Leamy, et al., 2011) and previous research (McNaught, et al., 2007; Nelson, et al., 2014; Salzer & Brusilovskiy, 2014). A strong and positive relationship between Questions 19 and 20 was also found as expected. Both Questions 19 and 20 therefore meet the minimum evaluation criteria for convergent validity.

Sensitivity to change

The ability of a measure to detect changes over time is an important characteristic of consumer-based outcome measures (Fitzpatrick, et al., 1998). While recovery ratings for some individuals may worsen in the initial stages of treatment, small changes were expected within the first 6-weeks. Scores on both Questions 19 and 20 were found to increase on average between treatment entry and 6-week review. The amount of improvement in scores was similar to that reported by Nelson and colleagues (2014) for Question 20 over a period of four weeks among US veterans in an inpatient addiction programme.[18] The minimum criteria for sensitivity to change of Questions 19 and 20 has therefore been met.

[17] That is, the frequency of general mental health problems interfering with daily life, arguments with friends or family members, and problems with work or other activities.

[18] While recovery ratings on Question 20 at treatment start were lower on average among US veterans, the amount of change in recovery was similar to that found in the US over a period of 3-months (Cacciola et al., 2013).

Reliability

Reliability is concerned with the consistency of results produced by a measure at different times or by different raters (Coolican, 1994). US research indicates Question 20 has excellent test-retest reliability (Cacciola, et al., 2013). When the inter-reliability of Question 19 was assessed by Galea and colleagues (2013) it was found to be positive but low. The use of different response options can potentially improve inter-rater reliability. Therefore the acceptability of several different response options to Question 19 were explored. There was some evidence to suggest consumer leaders preferred a 5-point verbal likert-type response scale, rather than the 10-point numerical response scale currently used in the ADOM. There was no clear preference amongst practitioners surveyed. Nevertheless, the inter-rater reliability found by Galea and colleagues (2013) was re-calculated in post hoc analyses using the guidelines set out in the information systems guide onto a 5-point scale (Te Pou., 2014a).[19] A high level of agreement between raters was found in post hoc analyses, with 7 out of the 8 practitioners having corresponding ratings. Evidence therefore indicates both Questions 19 and 20 have an acceptable level of reliability.

Minimum evaluation criteria

Questions 19 and 20 have met the minimum evaluation criteria set a priori for determining whether they should be recommended to the Ministry of Health for routine use in adult community-based (outpatient) addiction services. Table 11 indicates Questions 19 and 20 are acceptable to consumers, are feasible and useful to administer in clinical practice, and have an acceptable level of convergent validity, and sensitivity to change. Evidence was also found indicating that both Questions 19 and 20 have a sufficient level of reliability following post hoc analyses.

Table 11. *Question 19 and 20 Results Compared with Minimum Evaluation Criteria*

Test	Minimum evaluation criteria	Question 19	Question 20
Acceptability	Moderately acceptable and useful on average for thinking about recovery among consumer leaders	Yes	Yes
	Less than 10-15% missing data collected in clinical settings	Yes	Yes
Clinical utility	Moderately feasible to administer and useful on average for thinking about recovery amongst practitioners	Yes	Yes
Convergent validity	Statistically significant and negative relationships with ADOM indicators of mental and social wellbeing	Yes	Yes
	Statistically significant and positive large relationship with each other	Yes	Yes
Sensitivity to change	Significant mean differences in scores between treatment entry and 6-weeks	Yes	Yes

[19] Response option 0 was scored the same as 1 and 2.

Strengths and limitations

Based on data collected from a range of sources and addiction settings, the project provides evidence indicating that Questions 19 and 20 meet minimum standards for consumer-rated outcome measures. However, several limitations need to be taken into account when interpreting the project's findings.[20]

Valuable insights for this project were gained from a small convenience sample of consumer leaders via the Matua Raki Consumer Leadership Group, which represents the diversity of people accessing addiction services. It would have also been useful to talk to consumers in clinical settings who are likely to currently be at different places in terms of their wellbeing and recovery journey, and may have different levels of literacy and understanding of the concept of recovery.

The current study gathered feedback from a small sample of practitioners working in two organisations.[21] As the professions of practitioners was not gathered, it is not possible to assess whether the views of different professional groups vary. In addition, the level of readiness to implement the ADOM and the perceived benefits amongst practitioners may differ in other clinical settings. Use of Questions 19 and 20 may also be more challenging in some contexts and with some population groups. The utility of the recovery questions in residential settings also requires testing.

Recovery is an individual process that is aided by a range of factors over time. Consumers may appear to have made little recovery progress based on their ratings of Questions 19 and 20 if their recovery goals have changed. Such ratings may also inappropriately suggest that treatment has been ineffective. The tool can nevertheless help facilitate discussion with consumers about their recovery aspirations and the process of recovery. There may however be differences in practitioner's and consumers' understandings of the recovery concept. The inclusion of a recovery definition within the ADOM may help facilitate greater shared understandings and more standardised administration. There is also growing interest in exploring perspectives on the concept of recovery and wellbeing across the diversity of clients which will assist in refining the ADOM and other client-based outcome measures.[22]

The results in this report are based on pooled data provided by two organisations. While potential differences in the results were examined in preliminary analyses, the data from only one organisation was used in sensitivity to change analyses. This largely reflects the length of time the ADOM has been voluntarily implemented within different organisations. Once data is available over a longer time period, it would be beneficial to undertake further analyses.

Finally, the results show that Question 19 with a 10-point response option has a sufficient level of acceptability. Post hoc analyses of previous research with practitioners also suggests Question 19 has an acceptable level of

[20] Te Pou is particularly grateful for the feedback and comments from Dr Daryle Deering and Dr Simon Adamson that have been instrumental in the development of this section of the report.

[21] Selected by their organisations to participate and working within services who are voluntarily implementing the ADOM.

[22] Deering and colleagues are currently examining perceptions of recovery amongst clients receiving OST in GP care settings (D. Deering, personal communication, February 2015).

inter-rater reliability. As a consumer-rated item, an examination of the test-retest reliability of Question 19 would be most appropriate and valuable to undertake in future research. In addition, there was some preference amongst consumer leaders surveyed for an alternative 5-point verbal response scale to Question 19. Ideally this project would have gathered data in clinical settings to compare the psychometric properties, acceptability and utility of the two response options to identify the optimal response choice. However, continued use of the 10-point response option to Question 19 within the ADOM was considered most pragmatic due to available resources and the project timeline.

Summary

In summary, this project provides clear evidence that the two global recovery questions included in Section 3 of the ADOM meet minimum standards for their introduction to routinely assess consumers' recovery as part of the full measure in adult community-based (outpatient) addiction services. Findings indicate measurement of their recovery process is beneficial for consumers. The tool is reportedly enabling better engagement and discussion with consumers about their recovery and progress. As a result, consumers may be more involved in their treatment and engaged in their own care, leading to better treatment outcomes (see Donnelly et al., 2011; Goodman, McKay, & DePhilippis, 2013). For practitioners, the routine collection of recovery data can help in assessing treatment progress, informing future planning, identifying the need to make treatment changes, and reflecting on one's own practice (see Donnelly, et al., 2011; Hatfield & Ogles, 2004). At a service level, standardised recovery outcome data is useful for informing and demonstrating a commitment to recovery oriented service planning and delivery.

Recommendations

Key recommendations based on the project's findings are outlined below.

- Both Questions 19 and 20 should be considered for routine use as part of the ADOM in adult community-based (outpatient) addiction services in New Zealand as they meet minimum psychometric testing standards for a consumer-rated outcome measure
- Continue to use the 10-point response option to Question 19 within the ADOM. Several response options to Question 19 were investigated to potentially improve its reliability. While there was some preference for a 5-point verbal response option among consumer leaders, the 10-point response option to Question 19 currently used in the ADOM was found to have a sufficient level of inter-rater reliability and acceptability
- Undertake additional research examining the test-retest reliability, concurrent validity against more comprehensive recovery measures, and the generalisability of results to different populations and clinical settings to build a stronger evidence base. The psychometric properties of Questions 19 and 20 have been tested to a minimum acceptable level for routine clinical use.

Appendix A: ADOM

Alcohol and drug outcome measure (ADOMv2)

Alcohol and Drug Outcome Measure (ADOM)

Client Name:..... NHI:..... DOB:.....

Gender: ☐ *Male* ☐ *Female* Ethnicity:.....Team:.....

Referral Date: ..... Referral Source:..... ☐ *Mandated* ☐ *Voluntary*

Reason for collection:

Treatment Start: ☐ *New* ☐ *Other AOD Service* ☐ *Assessment only (up to 2 contacts)*

Treatment review: ☐ *6 weeks* ☐ *12 weeks*

Treatment End: ☐ *Routine* ☐ *DNA* ☐ *Other AOD Service* ☐ *Other*

Date of Collection:.....Collected by:..... Number of days covered: ..... *(7-28)*

Focus of care: ☐ *Engagement/Assessment* ☐ *Active Treatment* ☐ *Continuing care* CEP: ☐ *Yes* ☐ *No*

Section 1: Alcohol and other drug use

In the past four weeks how many days did you use/drink:	Days used 0-28	Notes	Main substance of concern
1. Alcohol			
2. How many standard drinks did you consume on a typical drinking day?		Refer to ALAC conversion chart (over page)	
3. Cannabis			
4. Amphetamine-type Stimulants		e.g. Methamphetamine, speed, Ritalin	
5. Opioids		e.g. poppies, poppy seed, morphine, Nurofen plus, codeine	
6. Sedatives/Tranquilisers		e.g. Diazepam (Valium), Temazepam, Benzos	
7. Any other drugs? Specify what drugs (maximum of 3 'other drugs')		e.g. Ecstacy, hallucinogens, solvents, GHB, party pills etc	
1.		If 'other drugs' contains substances covered in the above questions please return to the appropriate question and recode	
2.			
3.			
8. How many cigarettes have you smoked per day, on average?		50gm tobacco = 100 cigarettes	
9. Main substance of concern. For Questions 1 to 8 above, please identify up to three main substances of concern by writing a 1, 2 or 3 in the right hand column to identify priority.			
10. On how many days have you injected drugs?		If none, enter 0 and go to question 12.	
11. Have you shared any injecting equipment? ☐ Yes ☐ No		See over to clarify 'shared'.	

Section 2: Lifestyle and wellbeing

In the past four weeks :	Not at all	Less than weekly	Once or twice a week	Three or four times a week	Daily or almost daily
12. How often has your general physical health caused problems in your daily life?					
13. How often has your general mental health caused problems in your daily life?					
14. How often has your alcohol or drug use led to problems or arguments with friends or family members?					
15. How often has your alcohol or drug use caused problems with your work or other activities in any of the following: social, recreational, looking after children or other family members, study or other personal activities?					
16. How often have you engaged in any of the following: paid work, voluntary work, study, looking after children or other caregiving activities?					
17. Have you had difficulties with housing or finding somewhere stable to live?					
18. How often have you been involved in any criminal or illegal activity such as driving a motor vehicle under the influence of alcohol or drugs, assault, shoplifting, supplying an illicit substance to another person? (do not include using illegal drugs)					

Section 3: Recovery

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

20. How satisfied are you with your progress towards achieving your recovery goals?

☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

Previous testing and validation of the ADOM

Table 12 presents the findings of previous research which have tested the ADOM. The results of Sections 1 and 2 testing are included, along with those focused specifically on Section 3 – the recovery Questions 19 and 20. Evidence is summarised in relation to the key criteria recommended by Fitzpatrick and colleagues (1998) when considering the selection of consumer-rated outcome measures.

Table 12. *Testing of the ADOM against Key Criteria for Selecting Consumer-Rated Outcome Measures*

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
Appropriateness	Consider the match of an instrument to the specific research purpose and questions	• Deering et al. (2009) asked clinicians and clients whether the ADOM would be an acceptable and brief outcome/review tool for use with clients (i.e., to support current or future processes of review of treatment progress in relation to alcohol and drug use) • Wheeler et al. (2011) asked clinicians and researchers about their view on using the ADOM to evaluate client outcomes in practice.	Deering et al. (2009) found that most clinicians thought that with potential amendments the tool would be acceptable and useful as a brief outcome/review tool for use with clients. Wheeler et al. (2011) found the ADOM was an effective therapeutic tool facilitating clinical practice through recording change in client substance use and impact of use over time. Aggregated data enabled the treatment service to also evaluate the effectiveness of their intervention programme. However, the ADOM appears to be more limited as an assessment tool as it does not collect enough information about quantity and dependence.[23]		
Reliability	Internal consistency (how well items within a scale measure a single underlying dimension)				Cacciola et al. (2013) found Question 20 on recovery satisfaction loaded onto a 'recovery protection' factor which

[23] 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 (Wheeler et al., 2011).

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
					also included abstinence confidence, self-help group attendance, and religion/spirituality in supporting recovery among a group of US veterans in an outpatient substance abuse programme. The scale was internally consistent – α =0.78. Nelson et al. (2014) examined the internal consistency of a revised BAM measure, but did not include Question 20 in their analyses.
	Test-retest reliability	• Assess whether the instrument produces the same results on repeated administrations when respondents have not changed • Compare measurements made by the same observer/raters at two points in time; timeframe should be short enough that the construct itself hasn't changed • Test-retest reliability is assessed with Cohen's kappa (k) for categorical and ordinal data and intraclass correlation coefficients for continuous data (Pulford et al., 2010).	Deering et al. (2009; Pulford et al., 2010) examined the test-retest reliability with 61 AOD clients from seven general outpatient addiction treatment units and two OST services in Auckland and Christchurch. They found test-retest results for Part A were consistently good and for Part B were satisfactory after a mean of 3.1 days (*SD* = 2.1).		Cacciola et al. (2013) compared clinician (M = 3.25, *SD* = 0.92) and researcher ratings (M = 3.07, *SD* = 1.12) for Question 20 to test the test-retest reliability at the 3-month follow-up among a group of 88 US veterans in an outpatient treatment programme. The intraclass correlations (ICC) of 0.86 indicates Question 20 has excellent test-retest reliability.
	Inter-rater reliability (the extent to which two or more raters agree in their rating of outcome measures)	• Compare two or more of the observers/raters at a point in time • Percentage of overall agreement, kappa		Galea et al. (2013) assessed inter-rater reliability of the ADOM through two scenarios and clinician input with eight clinicians working at CADS West. A positive agreement was found	Galea et al. (2013) assessed the inter-rater reliability for Question 19 among eight clinicians working at CADS West. The question was found to have low but positive inter-rater

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
				for most questions.	reliability.[24]
Validity	Instrument development	• The extent of involvement in instrument development by experts with relevant clinical or health status measurement experience, and consumers in developing instrument content			
	Content validity	• Judgement on whether an instrument content adequately covers the domain of interest • Do the items included in the measure adequately represent the universe of questions that could have been asked?			
	Face validity	• Whether an instrument appears to be measuring the domain of interest • Measurement is accepted by those concerned as being logical on the "face of it" • Deering et al. (2009) asked both clinicians and clients about the most and least relevant questions and whether any additional questions should be included. • Galea et al. (2013) asked clients and clinicians through a series of nine focus groups about the clarity, accessibility, and intention of Part B questions • Cacciola et al. (2013) investigated the choice, acceptability, utility, and	Development of the original version of the ADOM involved a series of consultations and review process, which included an expert panel of clinical leaders, key informants including Māori, Pacific representatives, clinicians and consumers (Deering et al., 2010). Participants critiqued suggested questions on the basis of their face validity and perceived utility in an AOD clinical context (Pulford et al., 2010). Feedback led to amendments and additions to Sections 1 and 2 led to the resulting ADOMv1.	Galea et al. (2013) updated questions in Part B in order to improve the clarity and wording based on nine focus group interviews with clinicians and clients.[25]	Galea et al. (2013) assessed the recovery Question 19 among a sample of 40 clients from CADS West. A good number noted the usefulness of this question as a method to track their recovery. Review and feedback obtained from eight practising clinicians and a scientific advisory group by Cacciola et al. (2013) in the US led to the development of a revised version of the BAM.[26] They also sought feedback from 25 veterans on the perceived value of each item and other

[24] However, the free-marginal kappa indicates the inter-rater reliability for both scenarios was low.

[25] Results are contained in an unpublished report. *Alcohol and Drug Outcome Measure – Part B,* A report from nine discussion groups on the clarity and accessibility of the seven questions in Part B along with recommendations for improvement.

[26] Most items included in the Brief Addiction Monitor (BAM) were adapted from reliable and valid items within other instruments (Cacciola et al. 2013).

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
		wording of items, and the overall content coverage; suggestions for revisions, deletions and additional items.			items which they might recommend.
	Criterion validity (the extent to which an instrument correlates with another instrument or measure that is regarded as more accurate or criterion variable)	• Does the new measure agree with an external criterion, e.g., an accepted measure? • Predictive evidence = predictive of future event or outcome of interest • Concurrent evidence = correlation with "gold standard" at the same point in time; shortened scale with full-scale	Pulford et al. (2011; Deering et al., 2009) examined the concurrent validity of the ADOM in seven general outpatient addiction treatment units and two opioid substitution treatment services in Auckland and Christchurch. Strong relationships were found between Section 1 of the ADOM and the measures of Degree of Drug Use Index (DDI) and Timeline Follow Back (TLFB).[27] When Section 2 was compared with measures of Treatment Outcome Profile and SF-36 the results were more variable but satisfactory.[28] [29]	Galea et al. (2013) compared the revised ADOM Section 2 to existing psychometrically sound instruments to assess concurrent validity with a sample of 40 AOD clients from CADS West. Overall, most of the revised questions correlated better with the TOP and SF-36 than the original questions.	Galea et al. (2013) did not test the concurrent validity of Question 19 with the TOP or SF-36 as no measures could be compared to this question. Cacciola et al. (2013) found the factor "recovery protection" which includes Q20 predicted US veterans who dropped out of an outpatient substance abuse treatment programme. Nelson et al. (2014) tested the convergent and divergent validity of BAM-D items. Among a sample of 617 US veterans taking part in an inpatient substance abuse programme, Nelson et al. (2014) found Question 20 had a moderate relationship with the WHOQOL-BREF Psychiatry subscale ($r = 0.33$, $p < .001$). Small and statistically significant (p

[27] Degree of drug use is a self report method of collecting substance use data from New Zealand Maori and non-Maori participants which demonstrated reliability, validity and sensitivity to change in a New Zealand setting. The Timeline Follow Back is an internationally valid and reliable calendar self-report method for collecting substance use data (see Deering et al., 2010).

[28] Treatment Outcome Profile (TOP) contains questions pertaining to injecting risk behaviour, criminal activity, health and social functioning over a four week period. The SF-36 Health Survey includes two multiple response questions pertaining to problems with work or to their regular daily activities as a result of physical health or emotional problems (see Deering et al., 2010).

[29] Deering et al. (2009) noted that testing of ADOM Section 2 may be improved by using alternative comparative measures.

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
					<.001) relationships were also found with the environmental (*r* = 0.22), social health (*r* = 0.24), and total (*r* = 0.27) WHOQOL-BREF subscale scores. No relationship was found with the Addiction Severity Index (ASI) subscale scores. In a group of 152 US veteran outpatients, Nelson et al. (2014) found Question 20 had moderate and statistically significant (*p* <.001) relationships with multiple WHOQOL-BREF scores, including the psychological health (*r* = 0.33), social health (*r* = 0.30) and total subscales (*r* = 0.35). Although not statistically significant (probably due to the small sample size), Question 20 was also correlated with the environmental subscale (*r* = 0.27). No relationships emerged with the ASI subscale scores.
	Construct validity (in the absence of a criterion variable, validity testing takes the form of construct validation)	• Construct validity is assessed by comparing the scores produced by an instrument with sets of variables. To facilitate the interpretation of results expected levels of correlation should be specified at the outset of studies • Is the measure consistent with the theoretical concept being measured? All tests of validity ultimately designed			

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
		to support/refute the instruments construct validity; construct validity is never fully established. • Convergent evidence = demonstrate that your measure correlates highly (0.5-0.7) with measures of the same construct; groups known to differ along construct have significantly different scores on measure • Discriminant evidence = low correlation with instruments measuring a different construct; or differences between known groups • Factorial evidence = clustering of items supports the theory based grouping of items			
	Factor analysis (empirical support for the dimensionality or internal construct validity of an instrument)	• See above			Cacciola et al. (2013) found Question 20 on recovery satisfaction loaded onto a "recovery protection" factor which also included abstinence confidence, self-help group attendance, and religion/spirituality in supporting recovery among a group of US veterans in an outpatient substance abuse programme. The scale was internally consistent (α =0.78). The factor analyses undertaken by Nelson et al. (2014) did not include Question 20 and yielded slightly different solutions from Cacciola et al. (2013) among US

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
					veterans when items were measured on a different response scale.
Responsiveness	Addresses whether an instrument is sensitive to changes of importance to consumers.	• Usually assessed by examining changes in instrument scores for groups of clients whose health is known to have changed. This may follow an intervention of known efficacy. • Alternatively, clients may be asked how their current health compares to some previous point in time by means of a health transition question. • There is no single agreed method of assessing responsiveness and a number of statistical techniques are used for quantifying responsiveness (e.g., effect size, standardised response mean) • Pulford et al. (2010) assessed sensitivity to change using paired sample t-tests and the Reliable Change Index (RCI) for continuous data, the McNemar test for categorical data and the Wilcoxin Signed Ranks test for ordinal data.	Pulford et al. (2010; Deering et al., 2009) examined sensitivity to change with 56 AOD clients from seven general outpatient addiction treatment units and two OST services in Auckland and Christchurch. They assessed sensitivity to change on average 33.9 days (*SD* = 10.7) following baseline measures. For both Sections 1 and 2, many variables showed little change. However, greater change was evident for Section 1, and included reductions in alcohol, opioids, sedatives/tranquilisers, and injected drug use, as well as the mean number of standard drinks consumed per dinking. For Section 2, changes were reported for physical and psychological health. Results for Section 1 were considered excellent and for Section 2 satisfactory.[30]		Cacciola et al. (2013) found recovery satisfaction had significantly improved when the baseline (M = 2.46, *SD* = 1.79) and 3-month follow-up (M = 3.23, *SD* = 0.91) scores for Question 20 were compared for 84 US veterans. Nelson et al. (2014) found an improvement in Question 20 recovery satisfaction between treatment entry and the end of treatment (approximately 4 weeks) in an inpatient sample of US veterans in a substance abuse treatment programme. At treatment entry, 48 per cent were 'considerably' or 'extremely' satisfied with their recovery progress (*N* = 617) compared with 78 per cent at treatment completion (*N* = 465). The effect size was *d* = 0.56. Significant and meaningful changes were also observed on the WHOQOL-BREF Psychological, Physical, Environmental and Total Health Scales. Small relationships were

[30] Deering et al. (2009) noted that testing of ADOM Section 2 might be improved if a longer timeframe for the sensitivity to change analysis was employed (for example, 8-12 weeks).

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
					found for the change scores between Q20 and WHQOL BREF-Psychological (r = 0.16, p <.001)) and Total Health subscales (r = 0.15, p<.001) A similar effect size (d = 0.54) was found in the outpatient sample with 49 per cent being 'considerably' or 'extremely' satisfied with their recovery at treatment entry (N = 152) compared with 91 per cent at treatment completion (N = 55). Significant and meaningful changes were also observed on the WHOQOL-BREF Psychological and Total Health Scales. No relationship was found between the change scores on Q20 and the WHOQOL-BREF subscales.
Precision	Precision is concerned with the number and accuracy of distinctions made by an instrument	• Acceptability of response scales • Distribution of scores (floor or ceiling effects).			Cacciola et al. (2013) found responses to Question 20 were skewed at baseline among a group of US veterans (N = 150) taking part in an outpatient substance abuse programme with 57 per cent of participants being 'considerably' or 'extremely' satisfied with their recovery progress (M = 2.60, SD = 1.24, skewness = -2.94). At baseline, Nelson et al. (2014)

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
					found 48-49 per cent of US veterans in inpatient ($N = 617$) and outpatient ($N = 152$) substance abuse treatment programmes were 'considerably' or 'extremely' satisfied with their recovery progress. The response distribution was generally normal on intake and strongly skewed (negative ceiling effect) at post-treatment. They concluded that at least in the current sample, patient perception of their own progress may not be a reliable indicator of actual progress. However, individuals who withdrew from treatment early were not included in analyses of Q20 and the subsequent range restriction may have had a deleterious effect on item correlation patterns. Nelson et al. (2014) also concluded that other questions included in the BAM were better measured on the original quasi-continuous response options than the 5-point likert scale used in the revised version given they appear to be more psychometrically sound.[31]

[31] *Note.* There were no changes to Question20 between the original and revised version of the BAM.

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
Interpretability	Interpretability is concerned with how meaningful are the scores from an instrument				
Acceptability	How acceptable is an instrument for respondents to complete?	• Administration time • Response rates, and levels of missing data • Can ask patients if any questions are difficult or distressing • Deering et al. (2009) asked clients about the clarity of instructions, whether they found any items offensive or upsetting, and views on the tool's design and layout • Cacciola et al. (2013) asked veterans about their understanding of items, the extent to which they felt they could answer each item honestly, and what other items they might recommend.	Development of the original version of the ADOM involved consultation with an expert panel which included consumer representatives, as well as feedback from 22 AOD clients who had completed the measure. Most clients did not find any items offensive; the measure was also described as easy to follow and had a good design. Feedback from clients contributed to further development of the ADOM.		Cacciola et al. (2013) found that items on the BAM which includes Question 20 were generally well understood by and acceptable to US veterans from an outpatient substance abuse programme. Modifications or deletions were made in the few cases when this was not so. Items with very low endorsement rates were considered for deletion. Nelson et al. (2014) found low levels of missing data on a revised version of the BAM including Question 20 among US inpatient and outpatient veterans in a substance abuse treatment programme.
Feasibility	The extent of effort, burden and disruption to staff and clinical care arising from use of an instrument	• Ease of administration and processing • Complexity and length of the measure • Staff attitudes towards the measure • Time to complete measure • Deering et al. (2009) asked participants to complete a client or clinician questionnaire. This included the clinician's level of comfort and inconvenience experienced when administering the tool, as well as their views on the tool's accuracy and the feasibility of ongoing administration	Development of the original version of the ADOM involved a series of consultations and review process, which included an expert panel of clinical leaders, Māori, Pacific, clinicians, consumers and service managers. Feedback was also sought from 22 AOD clinicians who had used the measure. Deering et al. (2009) found time was perceived to be the greatest inconvenience in administering the ADOM, and the relationship between		

Criteria	Description	Methods	ADOM Sections 1 & 2 Original version	ADOM Sections 1 & 2 Revised version	ADOM Section 3
		• Wheeler et al. (2011) asked clinicians and researchers to provide feedback on the ease of use, clinical utility, and advantages/disadvantages in a real world practice	clinician and client was seen as having the greatest impact on the accuracy of results. However, clinicians thought that with potential amendments the tool would be acceptable and useful as a brief outcome/review tool for use with clients. Wheeler et al. (2011) asked clinicians and researchers about their views on using the ADOM to evaluate client outcomes in a CADs in Auckland as part of a pilot Offender Programme. The ADOM was found to be straightforward and brief to administer. There were however concerns about the number of assessment tools being used at AOD treatment entry.		
Adapted from Fitzpatrick et al. (1998) and Patient Reported Outcomes Measurement Group (n.d.).					

Appendix B: Minimum standards for client-based outcome measures

The International Society for Quality of Life Research (ISOQOL) has recently published recommendations for minimum standards for consumer-reported outcome measures based on a review of existing guidelines and a survey of members. The recommendations made by Reeve and colleagues (2013) for the use of patient-reported outcome (PRO) measures in patient-centred outcomes research or comparative effectiveness research are summarised in Table 13.

Table 13. *Minimum Standards for Client-Rated Outcome Measures*

No.	Area	Recommendations
1.	Conceptual and measurement model	A PRO measure should have documentation defining and describing the concept(s) included and the intended population(s) for use. In addition, there should be documentation of how the concept(s) are organised into a measurement model, including evidence for the dimensionality of the measure, how items relate to each measured concept, and the relationship among concepts included in the PRO measure.
2.	Reliability	The reliability of a PRO measure should preferably be at or above 0.70 for group-level comparisons, but may be lower if appropriately justified. Reliability can be estimated using a variety of methods including internal consistency reliability, test-retest reliability, or item response theory. Each method should be justified.
3.	**Validity**	
3a.	Content validity	A PRO measure should have evidence supporting its content validity, including evidence that patients and experts consider the content of the PRO measure relevant and comprehensive for the concept, population, and aim of the measurement application. This includes documentation of as follows: (1) qualitative and/or quantitative methods used to solicit and confirm attributes (i.e., concepts measured by the items) of the PRO relevant to the measurement application; (2) the characteristics of participants included in the evaluation (e.g., race/ethnicity, culture, age, gender, socioeconomic status, literacy level) with an emphasis on similarities or differences with respect to the target population; and (3) justification for the recall period for the measurement application.
3b	Construct validity	A PRO measure should have evidence supporting its construct validity, including documentation of empirical findings that support predefined hypotheses on the expected associations among measures similar or dissimilar to the measured PRO in the target population for the research application.
3c	Responsiveness	A PRO measure for use in longitudinal research study should have evidence of responsiveness, including empirical evidence of changes in scores consistent with predefined hypotheses regarding changes in the measured PRO in the target population for the research application.
4.	Interpretability of scores	A PRO measure should have documentation to support interpretation of scores, including what low and high scores represent for the measured concept.

No.	Area	Recommendations
5.	Translation of the PRO measure	A PRO measure translated to one or more languages should have documentation of the methods used to translate and evaluate the PRO measure in each language. Studies should at least include evidence from qualitative methods (e.g., cognitive testing) to evaluate the translations.
6.	Patient and investigator burden	A PRO measure must not be overly burdensome for patients or investigators. The length of the PRO measure should be considered in the context of other PRO measures included in the assessment, the frequency of PRO data collection, and the characteristics of the study population. The literacy demand of the items in the PRO measure should usually be at 6th grade education level or lower (i.e., 12 years old or lower); however, it should be appropriately justified for the context of the proposed application.
Source: Reeve, et al. (2013).		

Appendix C: Consumer leaders' survey

An online survey was developed using SurveyMonkey to gather feedback from consumer leaders, advisors, peer support workers and other consumer representatives. The survey was developed in consultation with consumer leaders and experts familiar with the ADOM and questionnaire development.

A survey invitation was sent to the Matua Raki Consumer Leadership Group who were also asked to share the survey with their colleagues. The invitation was sent out in the beginning of September 2014 and participants were given two weeks to complete the survey. Participants were advised that providing feedback was voluntary and that they would not be personally identifiable in the reported results. They were also provided with a definition of recovery from the *Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce* (2014).

Project results were shared with participants who requested these and the Matua Raki Consumer Leadership Group.

Invitation to provide feedback on ADOM Questions about Recovery

The Alcohol and Drug Outcome Measure (ADOM) has been developed to monitor changes in consumers' substance use, health and wellbeing, and recovery over time in AOD community treatment services.

The ADOM has been revised to reflect consumers' feedback. The ADOM (version II) currently includes two questions about recovery. These questions need reviewing to see how acceptable and useful they are for consumers.

We invite your feedback as an AOD consumer leader, advisor, representative or peer support worker on the questions about recovery. This will help inform the validation and recommendations to the Ministry of Health about future use of the recovery questions in AOD treatment services.

You can provide feedback by completing this brief online survey. Alternatively, contact Angela Jury, the researcher supporting the ADOM implementation project group, to discuss - email angela.jury@tepou.co.nz or phone (09) 300 6773
.

Please note:

- it is up to you whether you provide feedback or not
- only summary results will be reported - you will not be personally identifiable in the results.

Once the findings have been collated we can share these with you.

> *"**Recovery**…creating a meaningful self-directed life regardless of challenges faced, that includes building resilience, having aspirations and the achievement of these".*
>
> *(Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce,* 2014).

Te Pou o Te Whakaaro Nui

Matua Raki National Addiction Workforce Development

Feedback on Question 19

Question 19 asks "overall, how close are you to where you want to be in your recovery?"

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1. As a consumer please tick the box that best describes your answer.

	Disagree	Mildly agree	Moderately agree	Strongly agree
I understand this question				
This question is easy to answer				
I would be willing to answer this question				

2. How useful do you think this question is for:

	Not at all	Somewhat	Moderately	Very useful	Don't know
Facilitating dialogue and discussion between consumers and clinicians					
Monitoring the recovery progress of consumers					
Indicating how much consumers have benefited from treatment					

Please add any comments or thoughts you have about the use of this question

3. We're interested in whether this question will be able to detect meaningful change that occurs in people's recovery.

What sort of change in people's ratings would you expect to see over the following time periods?

	Decline or worsen	No change	Improve slightly	Improve moderately	Improve alot	Don't know
Treatment entry and 6 weeks						
Treatment entry and 3 months						
Treatment entry and 6 months						
Treatment entry and discharge						

Please add any comments or thoughts about the ability of this question to detect meaningful change

Preferred layout of Question 19

Here are some possible response options to Question 19. Please indicate your preferred option(s) below.

Option 1

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Option 2

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now.(5 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Option 3

19. Overall, how close are you to where you want to be in your recovery? Tick the response that best fits where you are now.

☐ Not at all close ☐ Slightly close ☐ Moderately close ☐ Very close ☐ Extremely close

4. Your preferred option(s)?

- Option 1
- Option 2
- Option 3

Please add any comments or thoughts about your preferred option(s)

Feedback on Question 20

Question 20 asks "how satisfied are you with your progress towards achieving your recovery goals?"

20. How satisfied are you with your progress towards achieving your recovery goals?

☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

5. As a consumer please tick the box that best describes your answer.

	Disagree	Mildly agree	Moderately agree	Strongly agree
I understand this question				
This question is easy to answer				
I would be willing to answer this question				

6. How useful do you think this question is for:

	Not at all	Somewhat	Moderately	Very useful	Don't know
Facilitating dialogue and discussion between consumers and clinicians					
Monitoring the recovery progress of consumers					
Indicating how much consumers have benefited from treatment					

Please add any comments or thoughts you have about the use of this question

7. What sort of change in people's ratings would you expect to see over the following time periods?

	Decline or worsen	No change	Improve slightly	Improve moderately	Improve alot	Don't know
Treatment entry and 6 weeks						
Treatment entry and 3 months						
Treatment entry and 6 months						
Treatment entry and discharge						

Please add any comments or thoughts about the ability of this question to detect meaningful change

Additional feedback

8. Are there any other questions about recovery that you would recommend including in the ADOM?

9. Any other comments or feedback?

10. Your name? (optional)

11. Ethnicity? (optional)

12. Are you a consumer leader, advisor, representative or peer support worker in the AOD sector

Yes
No

If no, please specify your role

13. Please include your email address below if you would like to receive a summary of the project findings once they are available

Thank you for providing feedback.

The next steps will involve looking at data collected by several organisations who are already using the ADOM, and seeking feedback from clinicians within these services. Once project findings have been collated we will be able to share these with you.

If you have any questions or would like to provide further feedback contact Angela Jury - email angela.jury@tepou.co.nz or phone (09) 300 6773.

Thank you for your time.

Appendix D: Practitioner's survey

An online survey was developed using SurveyMonkey to gather feedback from practitioners. Feedback from the consumer leaders' survey was incorporated in the survey development.

A survey invitation was sent to CareNZ and Northland DHB who were asked to share the invitation with their practitioners. The invitation was sent out in November 2014 and participants were given less than two weeks to complete the survey. Participants were advised that providing feedback was voluntary and that they would not be personally identifiable in the reported results. They were also provided with a definition of recovery from the *Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce* (2014).

Summary project results were shared with participants who requested these and their organisation.

Feedback on ADOM questions 19 and 20 about recovery

Feedback on ADOM questions 19 and 20 about recovery

The Alcohol and Drug Outcome Measure (ADOM) aims to monitor changes in substance use, health and wellbeing, and recovery over time.

Following consultation and feedback, the revised ADOM (ADOM v2) incorporates two questions about recovery. These questions need reviewing to see how valid, useful and practical they are in AOD community treatment services.

We're inviting feedback from AOD clinicians to help inform the validation and recommendations to the Ministry of Health about future use of these questions in AOD community services.

You can provide feedback by completing this brief survey.

Please note:

- it is up to you whether you provide feedback or not
- you will not be personally identifiable in the results
- only summary results will be reported to the Ministry of Health
- a copy of the summary results will be sent to your organisation
- you can also request a copy of the summary results once they're available.

For further information about this project please contact Angela Jury by email angela.jury@tepou.co.nz or phone (09) 300 6773.

> *"**Recovery**…creating a meaningful self-directed life regardless of challenges faced, that includes building resilience, having aspirations and the achievement of these".*
>
> *(Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce,* 2014).

Te Pou o Te Whakaaro Nui

Matua Raki National Addiction Workforce Development

Feedback on ADOM questions 19 and 20 about recovery

Feedback on Question 19

Question 19 asks "overall, how close are you to where you want to be in your recovery?"

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1. As a clinician please tick the box that best describes your answer.

	Disagree	Mildly agree	Moderately agree	Strongly agree
I understand this question				
This question seems easy for clients to answer				
I feel comfortable asking clients to complete this question				

2. How useful is this question for:

	Not at all	Somewhat	Moderately	Very useful	Don't know
Facilitating dialogue and discussion with clients					
Monitoring the recovery progress of clients					
Indicating whether clients have benefited or not from treatment					

Please add any comments or thoughts you have about the use of this question

3. We're interested in whether this question detects meaningful change in recovery.

What sort of change in client ratings would you expect to see over the following time periods?

	Decline or worsen	No change	Improve slightly	Improve moderately	Improve alot	Don't know
Treatment entry and 6 weeks						
Treatment entry and 3 months						
Treatment entry and 6 months						
Treatment entry and discharge						

Please add any comments or thoughts about the ability of this question to detect meaningful change

Feedback on ADOM questions 19 and 20 about recovery

Preferred layout of Question 19

Here are some possible response options to Question 19. Please indicate your preferred option below.

Option 1

19. Overall, how close are you to where you want to be in your recovery? Tick the number that best fits where you are now. (10 is the best possible)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Option 2

19. Overall, how close are you to where you want to be in your recovery? Tick the response that best fits where you are now.

☐ Not at all close ☐ Slightly close ☐ Moderately close ☐ Very close ☐ Extremely close

4. Your preferred option(s)?

- Option 1
- Option 2

Please add any comments or thoughts about your preferred option(s)

Feedback on ADOM questions 19 and 20 about recovery

Feedback on Question 20

Question 20 asks "how satisfied are you with your progress towards achieving your recovery goals?"

20. How satisfied are you with your progress towards achieving your recovery goals?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

5. As a clinician please tick the box that best describes your answer.

	Disagree	Mildly agree	Moderately agree	Strongly agree
I understand this question				
This question seems easy for clients to answer				
I feel comfortable asking clients to complete this question				

6. How useful is this question for:

	Not at all	Somewhat	Moderately	Very useful	Don't know
Facilitating dialogue and discussion with clients					
Monitoring the recovery progress of clients					
Indicating whether clients have benefited or not from treatment					

Please add any comments or thoughts you have about the use of this question

7. What sort of change in client ratings would you expect to see over the following time periods?

	Decline or worsen	No change	Improve slightly	Improve moderately	Improve alot	Don't know
Treatment entry and 6 weeks						
Treatment entry and 3 months						
Treatment entry and 6 months						
Treatment entry and discharge						

Please add any comments or thoughts about the ability of this question to detect meaningful change

8. Any other comments or feedback?

9. Your ethnicity? (optional)

- NZ European
- Māori
- Pacific
- Asian
- Other (please specify)

10. Gender? (optional)

- Male
- Female

11. Are you a clinician working in the AOD sector?

- Yes
- No

If no, please describe your role

12. Please send me summary results once they're available

- No
- Yes, please include your email address below

Email address

Feedback on ADOM questions 19 and 20 about recovery

Thank you for your time and feedback.

You can keep up-to-date with this project on the Matua Raki website or sign up to our e-news letter at www.matuaaraki.org.nz

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