Routine Outcome Measurement in Methadone Maintenance –
Feasibility and potential benefits

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EXECUTIVE SUMMARY

A well-designed and conducted assessment and outcome measurement system can produce benefits for both clients and service providers. One of the main benefits at RADS has been the improved quality of entry assessments. According to RADS policy, every client receives a standardised admission assessment and a regular review assessment. Using standardised tools guarantees that staff and clients regularly focus on each of the Methadone Maintenance Treatment (MMT) areas. It also means that the quality of assessment is less dependent on the experience of the case manager or general practitioner involved.

An additional benefit for both clients and clinicians has been the ability to focus on indicators of progress towards MMT goals – for example, towards safer needle use practices. Where outcomes are positive, clinicians can encourage clients. Where results are less positive, it is possible to start working on areas for improvement. If there are any barriers to progress, a skilful clinician can discuss these in a way which will hopefully lead to behavioural change.

A benefit for the MMT programme itself has been the ability to provide sound evidence of client progress on treatment. It is recognised that the production of indisputable evidence is beyond the scope of any programme – certainly within the constraints of a health and research funding environment in which resources are scarce. Nevertheless, RADS has been able to provide credible support for the effectiveness of MMT *as delivered at RADS.*

Based on our experience with the Opiate Treatment Index (OTI) and the Methadone Assessment Tool (MAT) we can commend their use to the field. A copy of the total MAT package is included as the Appendix. Nearly 800 packages have been completed since the project began several years ago which suggests that the tools have wider applicability than specialist, one-off research projects. In particular, we consider the MAT at both entry assessment and followup assessment to be the most practical and sustainable strategy.

It is recognised that our work in this area is part of a wider effort on the part of both treatment providers and researchers. The work of NCTD deserves specific mention. Hopefully, the end result of all our efforts will be the successful establishment in New Zealand of standardised assessment and outcome measurement as a routine part of practice.

ACKNOWLEDGEMENTS

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We would also like to recognise Dr Graeme Judson of the Taranaki Alcohol & Drug Service for his commitment to routine assessment and outcome measurement and for forming a partnership with RADS to trial the adapted OTI and the AIMS database.

Finally, thanks are due to Daryle Deering of the National Centre for Treatment Development – not only for her input, but also for her pioneering work in this area and her ongoing commitment to sound and clinically useful methadone outcome assessment in New Zealand.

INTRODUCTION

In spite of extensive research into the effectiveness of Methadone maintenance treatment (MMT) such as the work of Ball and Ross (1991), public perception of this approach to opioid dependence remains subject to suspicion from time to time.

Auckland Regional Alcohol and Drug Services (RADS) serves a population of approximately one million. It administers four outpatient alcohol and drug treatment units, a medical detoxification unit and a MMT programme for more than 700 clients.

In 1996 Auckland Regional Alcohol and Drug Services started to receive a series of "Ministerial questions" from Parliament about the effectiveness of the Auckland MMT programme. In the same year, the Ministry of Health introduced a formal requirement that New Zealand MMT programmes review treatment outcomes annually (MOH 1996). Later in 1996, a report to the Ministry of Health (Sellman et al 1996) recommended that government should focus on the issue of 'cost effectiveness' when making decisions about service delivery approaches. While the costs of MMT in New Zealand were known, the effectiveness of it could only be assumed on the basis of overseas experience. This was the context of the development of the routine outcome measurement programme described in this paper.

The project brief was handed over to the RADS Clinical Information and Research Unit (CIRU) where it was determined that the first step would be to develop a standardised clinical intake assessment. Outcomes would be indicated by repeating the assessment in a follow-up interview with clients as some point in the future – possibly during routine 6-monthly assessments.

During this exercise we were very aware that tradeoffs would have to be made between scientific rigour and the total cost to the organisation. Accordingly, it was decided that the assessment package had to be *adequate* for outcome measurement purposes – not that it had to be capable of producing *conclusive* evidence of effectiveness. The costs of achieving this latter goal were considered too high for the organisation relative to the likely benefits derived[1]. Having said this, we based our outcome measurement system on and around the most psychometrically credible tool available, the Opiate Treatment Index (OTI).

The aim of this paper is to demonstrate the feasibility and potential value of a routine outcome measurement system in methadone maintenance treatment with reference to the RADS experience.

It is recognised that RADS is not the only or even the first methadone treatment provider in New Zealand to explore standardised methadone assessment or outcome measurement. Similarly, it is acknowledged that CIRU is not the first research team to develop an outcome measurement package for use in New Zealand. As could be seen at the 1999 National Opioid Treatment Conference, considerable work has been going on nationally in this area. This has included the work of Glenys Dore, Jocelyn Walker, Jean Paice, and Sylvia Clarkson for the Otago Methadone Programme in Dunedin, Dr Stephen Duffy's use of the Methadone

[1] As Longabaugh & Lewis noted, "treatment outcome research is expensive, complex and difficult to carry out to successful completion" (Longabaugh & Lewis 1988, p.168). Furthermore, on top of the financial costs there is the often considerable burden on staff and managers of having to follow complex and demanding research protocols. Longabaugh & Lewis go so far as to say that "the single-site trial requires almost total clinical-administrative control by the researchers to assure the successful implementation of the research protocol" (Longabaugh & Lewis 1988, p.169). The benefits to the service (as opposed to the researchers involved) have to be very high to make such research attractive – especially in an environment of scarce health funding.

Treatment Index (MTI) in Christchurch, and the extensive work of the National Centre for Treatment Development (NCTD). Our intention here is to present the results of some of the work we have been doing in the hope that it will encourage the spread of much needed outcome measurement activity in the methadone treatment field.

IMPLEMENTING AN OUTCOME MEASUREMENT SYSTEM

An audit of intake assessment procedures found that there was no standard approach to MMT entry assessment at RADS. Client files showed various approaches to assessment over more than fifteen years. A one-page set of assessment "guidelines" was found taped to a window at the assessment unit but the content and focus of assessments (and what was recorded) remained at the discretion of the clinician.

The Opiate Treatment Index (OTI) was the favoured basis for our attempt to standardise assessment procedures for a number of reasons. It covered substance use, injecting and sexual risk-taking behaviours, social functioning, health and criminal activity and was known to have excellent psychometric properties (Darke et al 1992). Second, it had been recommended as the basis for clinical assessments in MMT programmes (Mattick & Hall 1993).

The OTI had been tested for clinical use in both the UK (Adelekan 1996) and in New Zealand (Deering & Sellman 1996). The results of both these studies showed few differences between the quality of information gathered by clinicians versus externally contracted researchers. Both studies however, noted some potential difficulties with the time and human resources required to administer the tool.

Adapting the OTI for routine clinical use

A number of modifications were made to the OTI prior to its introduction. The package was divided into three parts: (a) the case manager interview; (b) the medical interview, and (c) the health survey. This spread the burden of the assessment across more than one staff member and (usually) across more than one day.

The case manager interview included sections 1 to 5 of the original OTI with two additional sections covering assessment of dependence and regularity of opioid use required by the Ministry of Health. The recent drug use section was modified to include commonly used drugs in New Zealand. The medical interview included section 6 of the original OTI with some additional items relevant to medical assessment. The General Health Questionnaire (GHQ) included in the original OTI was replaced by the Short Form 36 (SF-36) Health survey (MOT 1994). This survey had received favourable consideration for use in the substance abuse field (Andrews et al 1994) and had been used successfully with opioid users in Adelaide (Ryan & White 1996). In addition, the SF-36 was becoming increasingly popular among health researchers in New Zealand and it offered the opportunity to gather comparable health data.

Item 11 of the HIV Risk-taking Behaviour Scale (HRBS) regarding the regularity of anal sex, was dropped based on a unanimous view that the invasive nature of the question outweighed

any clinical benefits gained by asking it. Two additional items were included in the Social Functioning section which were used to directly assess exposure to violent situations but were scored independently from the original scale. Eventually section 5 (regarding crime) was dropped due to an apparent reluctance among clients to answer questions as specific as these regarding their recent criminal activity.

In our view, factors assisting us to engage staff in the use of the tool included: well known management enthusiasm, comprehensive staff training, computerised data management, and computerised production of assessment summaries.

A staff training package was developed based on the OTI Manual (Darke et al 1991). Training focused on the clinical utility to be found in offering all clients a standard assessment covering all of the major outcome domains. It was stressed that the standardised assessment was *not* intended to replace clinical judgement. Staff were encouraged to make additional notes during the assessment as they saw fit and space was made in assessment forms to acknowledge this.

Staff were shown that the tool could be used to identify a range of issues which could be addressed in a variety of ways - from giving immediate information and advice, through to planned intervention or referral at a future date.

A user-friendly Windows-based database was developed which allowed centralised entry of assessment data. The database performed automatic calculation of all 'recent use' scores which meant that staff were able to avoid hours of tedious manual calculations. The database also produced an assessment summary which included key information which could be used to inform treatment planning. SPSS was employed to perform all other analysis of the data with an emphasis on wide dissemination of key results to staff and management.

Assessments using what by then was known as the "Adapted OTI" began in earnest from January 1996. Since that date, over 440 client assessments have been completed using the tool[2].

Requirements for a follow-up interview tool

Although there has been an expectation that case managers and general practitioners (GPs) conduct regular treatment reviews with their clients, in practice, these reviews have been done in a non-uniform way. In fact it appeared that some clients were not having their treatment reviewed at all. The opportunity arose for CIRU to have input into what such a review assessment should contain.

Our experience suggested that it would not be logistically possible to train and monitor all case managers across the region in the use of the adapted OTI. In addition, we wanted a tool that would be feasible for General Practitioners to use with the approximately 25% of RADS clients case managed by GPs. What was required was a tool that kept as many of the subscales and individual items of the adapted OTI intact as possible, and yet was shorter and simpler. This was the rationale for the development of the Methadone Assessment Tool (MAT).

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[2] For some time, clients were assessed using the adapted OTI at both entry to the programme waiting list and actual admission to the programme proper This figure includes waiting list assessments.

The drug use assessment section of the MAT retained the one month window of the 'recent use' method but asked for indications of average use. The HIV Risk-taking Behaviour Scale (HRBS) and the Social Functioning Scale were also retained in the MAT. A retrospective question regarding criminal activity was included. The MAT also included the SF-36 Health Survey as the measure of health status.

Although considerably shorter and easier to administer, the comparability between the adapted OTI data and the MAT has been highly optimised. Because the core components (the HRBS, Social Functioning Scale and SF-36) have all been subject to psychometric testing, we could be confident that the resulting data is as valid and reliable as can be obtained in a clinical setting.

Use of standardised MMT review assessments have now become part of formal RADS policy and the MAT is being trailed as the standard review assessment tool. At the time of submission, 332 MATs had been administered – 237 in specialist units across the Auckland Region, and 95 by community GPs.

BENEFITS OF OUTCOME MEASUREMENT

Benefits to clients

The implemented system of outcome measurement has produced direct clinical advantages. According to RADS policy, every client must now receive a standard admission assessment and standard regular review assessments[3]. This guarantees that staff and clients regularly focus on each of the key MMT outcome areas. It also means that the quality of assessment is less dependent on the level of experience of the case manager or General Practitioner (GP) involved. This is particularly valuable when experienced staff leave or new GPs take on a case manager role in the community. Clients seen by less experienced staff or GPs are no longer as disadvantaged as they may have been under the previous ad-hoc assessment system.

An additional benefit has been the ability to focus attention on progress - for example, towards safer needle-use practices. Staff can encourage clients where outcomes are positive or identify areas for improvement where results are not. Barriers to progress can be discussed openly paving the way for reflection, information giving, and ultimately, behaviour change.

Potential to demonstrate programme effectiveness

While this system of routine outcome measurement produces direct clinical benefits, it also has the potential to demonstrate the effectiveness of the programme as a whole. It may be thought that this is unimportant given the availability of international research providing MMT with a solid research base. Such research, however, does not show that MMT has been effective *as it has been implemented* in any given context. There are numerous variables which may impact on the effectiveness of a treatment programme and the issue can only be

[3] As is always the case, there is some gap between policy and practice. Nevertheless, well over 300 MATs have been completed since the introduction of the tool in mid-1999.

settled empirically[4]. In any case, some initial findings are presented below which provide an early indication that the RADS MMT programme is effective across key outcome domains.

Programmes wishing to use routinely gathered clinical information in this way do, however, need to take account of the way in which data is created.

Two studies have shown that the OTI produces similar results whether administered by researchers or clinicians (Adelekan et al 1996; Deering & Sellman 1996) and a recent review of studies into self-report among drug users concluded that "there is no reason to reject the use of self-report data as unreliable and invalid" (Darke 1998, p.261). With harm minimisation as a central goal, the Auckland programme attempts to work constructively with clients who report continued use of illicit opioids or other problems. Random urine testing also provides an additional source of drug use information to caseworkers and GPs alike. Under these conditions, the data reported here are adequately accurate to illustrate the role routine outcome measurement can play in evaluating the effectiveness of MMT.

The results presented in this paper are from 72 clients who were (a) assessed for entry to MMT after January 1996 with the adapted OTI package and (b) assessed during review assessments taking place during 1999 (average follow-up, approximately 18 months).

As this was a naturalistic evaluation, selection of follow-up clients was not formally randomised. As Table 1 shows, however, key characteristics of follow-up clients were very similar to those of the total population.

Table 1 ***Representativeness of follow-up clients***

	Population	
	Total assessed population	*Follow-up population*
n	331*	72
Age ± SD	31.2 ± 8.8	31.4 ± 9.0
Sex % male	63.7%	73.6%
Poly drug score ± SD	4.7 ± 1.6	4.7 ± 1.6
Drug use sub-total ± SD	9.5 ± 4.6	9.2 ± 5.0
Sexual behaviour sub-total ± SD	3.7 ± 3.3	3.7 ± 3.0
HIV Risk-taking Behaviour Scale ± SD	13.2 ± 5.9	12.9 ± 6.0
Social functioning score ± SD	19.1 ± 7.1	19.0 ± 6.9

* This figure excludes assessments of MMT clients transferring in to the Auckland Region and waiting list assessments

[4] The Institute of Medicine (United States) provided the following caution: `It used to be common for discussions of treatment outcome to be graced by a modest qualifying phrase: "Treatment X had the following result *in our hands*." ... Even with adequate quality assurance mechanisms in place ... there are likely to be differences between a treatment as studied in a research setting and the same treatment as delivered in a treatment setting' (Institute of Medicine 1990, pp.314-315).

Reduced drug use

Use of 11 different categories of substances were monitored at both admission and follow-up. Table 2 shows the number of clients using each of the drug categories in the 28 days prior to interview.

The major changes to drug use behaviour appeared for the categories: morphine tablets, homebake, "other opioids" and benzodiazepines (all changes significant to p = 0.001 or lower). The numbers of clients using cannabis, alcohol and tobacco remained approximately at intake levels.

Table 2 ***Changes in Drug Use in the 28 Days Prior to Assessment***

	Time of assessment				*Chi*: df=1; X^2; p*
	Admission		*Follow-up*		
	Count	%	Count	%	
morphine tablets	63	87.5	3	4.3	95; <0.001
homebake	29	40.3	4	5.6	22; <0.001
heroin	5	6.9	0	0.0	3; 0.071
other opioids	32	44.4	5	7.1	24; <0.001
benzodiazepines	39	54.2	16	22.2	14; <0.001
amphetamines	17	23.6	6	8.5	5; 0.025
hallucinogens	6	8.3	3	4.2	0.4; 0.505
cocaine	3	4.2	1	1.4	0.2; 0.622
cannabis	53	73.6	47	66.2	0.6; 0.433
alcohol	25	34.7	27	37.5	0.0; 0.862
tobacco	67	93.1	64	90.1	0.1; 0.744

* Yates continuity correction was applied to all calculations

Changes in OTI subscales

Statistically significant improvements were found across all comparable OTI subscales included in the adapted OTI/MAT package, using paired samples t-tests (see Figure 1 below). In all of the subscale results, lower scores indicate improvement.

The mean polydrug score reduced from 4.7 to 1.9 (t=15.75, df=70, $P_{two\text{-}tailed}$ <0.001). The mean drug use subscale of the HIV Risk-taking Behaviour Scale (HRBS) (measuring risk associated with needle use) dropped from 9.2 to 0.5 and mean scores for the sexual behaviour component of the HRBS dropped from 3.7 to 3.1. The combined mean HRBS score decreased from 12.8 to 3.7 (t=12.32, df=69, $P_{two\text{-}tailed}$ <0.001). Social functioning showed a smaller improvement (the mean score decreasing from 19.0 to 14.8) but again this was statistically significant (t=5.54, df=69, $P_{two\text{-}tailed}$ <0.001).

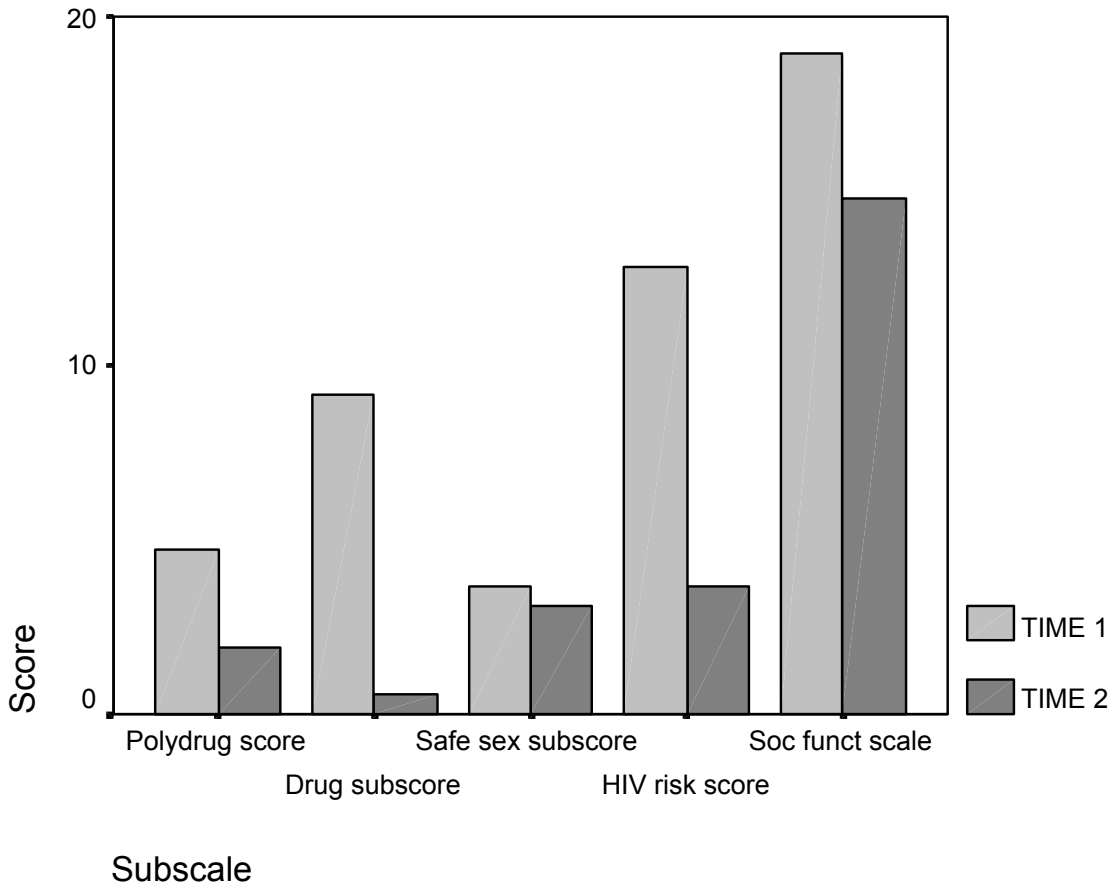

Figure 1 ***Decreased OTI Sub-scale scores Between Admission (Time 1) and Follow-up (Time 2)***

Improved health status

The SF-36 measures health across eight dimensions (see Table 3 below). Higher SF-36 scores reflect better health.

Table 3 ***Increased SF-36 Scores Between Admission and Follow-up***

SF-36-derived subscales - impact of MMT	*Time of assessment*		*Paired Samples t-test*: t ; df; p*	*New Zealand Norms (age sex weighted)*
	Admission	*Follow-up*		
General Health	41.7	53.5	4.9; 58; <0.001	75.6
Mental Health	46.1	65.4	7.2; 60; <0.001	78.0
Physical Functioning	69.8	77.2	1.7; 60; 0.093	90.7
Role Physical	24.7	59.6	5.0; 60; <0.001	84.2
Role Emotional	29.9	62.6	3.9; 56; <0.001	86.3
Bodily Pain	44.9	58.7	3.1; 60; 0.003	79.3
Vitality	35.7	51.1	5.5; 61; <0.001	66.3
Social Functioning	35.7	65.0	7.3; 61; <0.001	87.4

* Two tailed

Table 3 shows mean improved health for the sample across all dimensions, with statistical significance from 0.093 to below 0.001. Figure 2 displays these results in graphical form where it is easy to gauge the nature of health at both admission and follow-up. Age-sex weighted SF-36 norms obtained from a recent national health survey (MOH 1999) are also charted for comparison purposes.

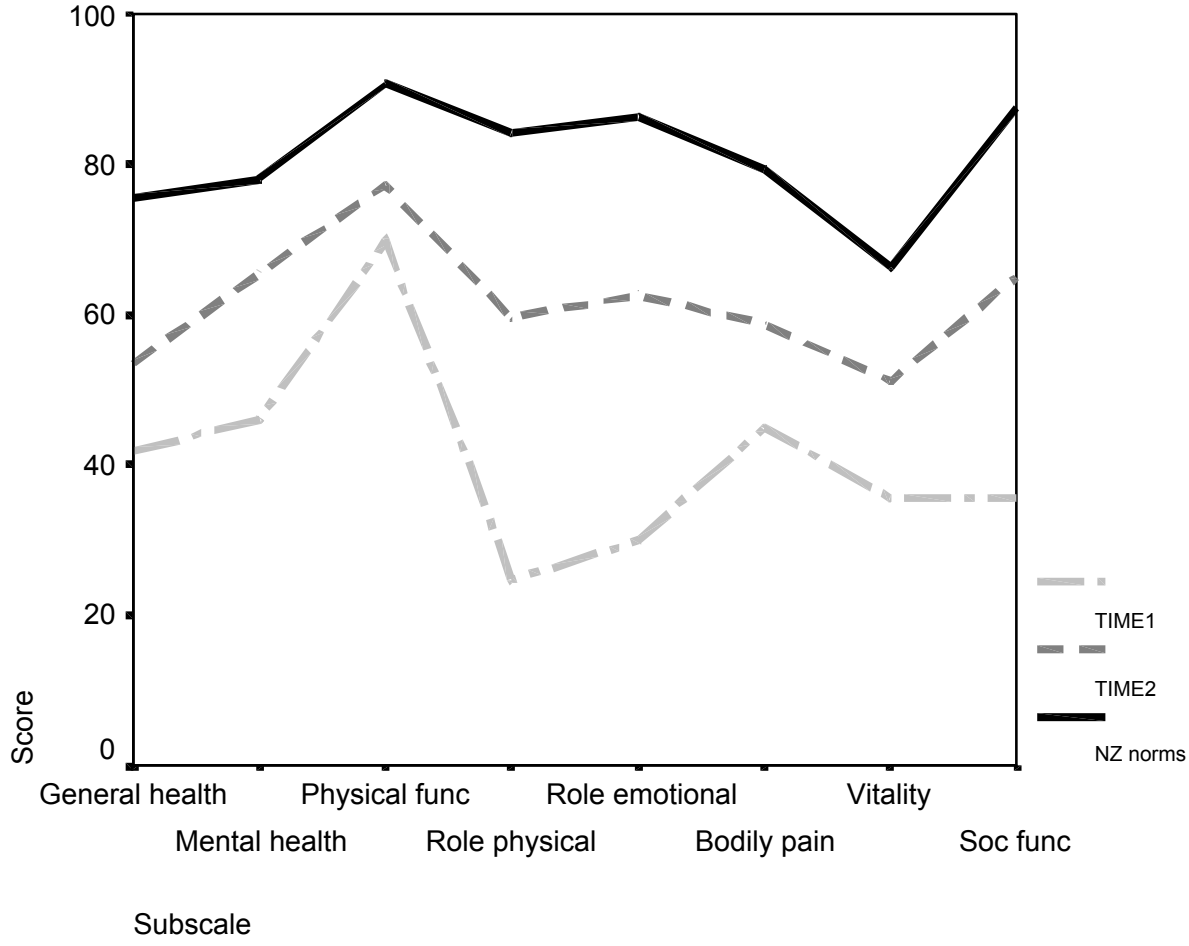

Figure 2 ***Improved SF-36 Client Health Status Between Admission (Time 1) and Follow-up (Time 2) as Compared with Auckland Norms***

Criminal involvement

In answer to a retrospective question about criminal activity, 2% claimed that their criminal activity since entering the programme had "stayed the same", 32% claimed that their criminal activity had decreased, and 66% reported that they had stopped all criminal activity.

CONCLUSION

This paper has described some of the background to implementing a system of routine outcome measurement for MMT. A variety of factors were considered critical for the success of the project including consultation with management and staff, staff training, development of a specialist database system, and feedback to staff and management on both individual and programme results.

Establishing a routine outcome measurement system at RADS has provided a number of benefits for both clients and the programme. These have included the following: clients are guaranteed regular assessment which focuses on the main MMT outcome areas; areas of client progress towards treatment goals are identified, as are areas requiring intervention; and the programme is able to demonstrate its effectiveness to stakeholders.

Although it has long been intended that the OTI be used in clinical settings (Darke et al 1991; Mattick & Hall 1993; Ward et al 1998) this is the first paper demonstrating its actual use as the basis for routine assessment and outcome measurement. This paper demonstrates that it is practical and sustainable to use the full (adapted) OTI for client entry assessments and a shortened version (the MAT), for follow-up assessments.

Having said this, we recognise that it is probably more practical and sustainable to use the MAT for both first assessment and followup. This is the direction RADS is now considering taking. The MAT preserves the HIV Risktaking Behaviour Scale and the Social Functioning Scale of the original OTI – both of which are known to have adequate psychometric credibility. Furthermore, utilising the same tool at both initial and followup assessment simplifies the task of data analysis.

Our recommendation is that other MMT programmes consider using the OTI and/or the MAT for routine outcome measurement. The more services using the same standardised tool, the greater the potential for the sharing of data, software, training resources, and expertise. Efficiencies of this sort are probably essential if outcome research is to be affordable in New Zealand. The MAT should be seriously considered for this role because of the extensive testing it has received and the existence of data on over 300 MATs for comparative purposes.

BIBLIOGRAPHY

Adelekan, M. & Metrebian, N. & Tallack, F. & Stimson, G.V. & Shanahan, W. (1996). Who Should Collect Opiate Treatment Index Data In Opiate Treatment Outcome Monitoring: Clinic Staff or Researchers? *Drug and Alcohol Review* 1996;15:65-71.

Andrews, G. & Peters, L. & Teeson, M. (1994). *The Measurement of Consumer Outcome in Mental Health: A Report to the National Mental Health Information Strategy Committee*. Sydney: Clinical Research Unit for Anxiety Disorders, 1994.

Ball, J.C. & Ross, A. (1991). *The Effectiveness of Methadone Maintenance Treatment. Patients, Programs, Services, and Outcome*. New York: Springer-Verlag.

Darke, S. (1998). Self-report Among Injecting Drug Users: A Review. *Drug and Alcohol Dependence* 1998;51;253-263.

Darke, S. & Hall, W. & Wodak, A. & Heather, N. & Ward, J. (1992). Development and validation of a multi-dimensional instrument for assessing outcome of treatment among opiate users: the Opiate Treatment Index. *British Journal of Addiction* 1992;87:733-742.

Darke, S. & Ward, J. & Hall, W. & Heather, N. & Wodak, A. (1991). *The Opiate Treatment Index (OTI) Manual, Technical Report no. 11*. Sydney: National Drug and Alcohol Research Centre, 1991.

Deering, D.E. & Sellman, D. (1996). An Inter-rater Reliability Study of the Opiate Treatment Index. *Drug and Alcohol Review* 1996;15:57-63.

Longabaugh, R. & Lewis, D.C. (1988). Key Issues in Treatment Outcome Studies. *Alcohol Health & Research World*, Vol.12, No.3, pp.168-175.

Mattick, R.P. & Hall, W. (1993). *A treatment outline for approaches to opioid dependence. Quality assurance in the treatment of drug dependence project*. Monograph Series No.21. Canberra: Australian Government Publishing Service.

Ministry of Health. (1996). National Protocol for Methadone Treatment in New Zealand. Wellington: Publisher.

— (1999). *Taking the Pulse. The 1996/97 New Zealand Health Survey*. Wellington: Publisher.

Medical Outcomes Trust. (1994). *SF-36 Health Survey - Scoring Manual for English-Language Adaptations: Australia/New Zealand, Canada, United Kingdom*. Boston: Medical Outcomes Trust, 1994.

Ryan, C.F. & White, J.M. (1996). Health Status at Entry to Methadone Maintenance Treatment Using the SF-36 Health Survey Questionnaire. *Addiction* 1996;91(1):39-45.

Sellman, J.D. & Hannifin, J. & Deering, D. & Borren, P. (1996). *Delivery of Treatment for People with Opioid Dependence in New Zealand: Options and recommendations*. A Commissioned Paper for the Ministry of Health, New Zealand.

Ward, J. & Mattick, R.P. & Hall, W. (1998). Assessment For Opioid Replacement Therapy. In: Ward, J. & Mattick, R.P. & Hall, W. *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*. Australia: Harwood Academic Publishers, 1998:177-204.

APPENDIX – METHADONE ASSESSMENT TOOL (MAT) – WAITING LIST/ADMISSION PACKAGE

PLACE CLIENT NAME AND ID LABEL HERE

Interviewer: _____

Interview Site: _____

Interview Date: __ / __ / __

1 ☐ Waiting List Assessment

2 ☐ Admission Assessment

3 ☐ Other (State type): _____

Methadone Assessment Tool

(MAT)

Waiting List/Admission Version

Developed by the Auckland Regional Alcohol & Drug Services

for use during methadone treatment assessments.

Derived From:

The Opiate Treatment Index (OTI)

University of New South Wales

The Methadone Treatment Index (MTI)
National Centre for Treatment Development (NCTD)
Christchurch School of Medicine

Includes:

The SF-36 Health Survey

Gen. Version 21-Sept-99

THE SF-36 HEALTH SURVEY

Information for Clients

Auckland Methadone Services aims to help clients improve their overall health. We are interested in how being on the methadone programme affects the health of clients.

This health survey is being used extensively in a range of health care settings internationally and has been carefully modified for the New Zealand setting.

We ask all new clients to complete this survey at the time they are assessed. It will take you about five minutes. As with all of your information provided during your assessment, it will be treated in accordance with the Privacy Act (1993) and the Health Information Privacy Code (1994).

In the long term we would like this survey filled out again. This is so changes in your health can be charted.

Because this survey is designed for use by all ages one or two questions may not seem very relevant to people in your age group. Please answer <u>all</u> questions as best you can.

At present we are trying out the SF-36 to see how useful it is. Feel free to write any comments you have about it on the back of the survey. Your opinion is valued.

All information given in this form is protected as per the Health Information Privacy Code 1994

Office use only

Client Name: .....

SF-36 HEALTH SURVEY

INSTRUCTIONS:

This questionnaire asks for your views about your health, how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

Excellent..... 1
Very good..... 2
Good 3
Fair 4
Poor 5

2. <u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?

(circle one)

Much better now than one year ago 1
Somewhat better now than one year ago ... 2
About the same as one year ago 3
Somewhat worse than one year ago 4
Much worse now than one year ago 5

3. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

(circle one number on each line)

<u>ACTIVITIES</u>	**Yes, Limited a Lot**	**Yes, Limited a Little**	**No, Not Limited At All**
a) **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
b) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	1	2	3
c) Lifting or carrying groceries.	1	2	3
d) Climbing **several** flights of stairs.	1	2	3
e) Climbing **one** flight of stairs.	1	2	3
f) Bending, kneeling, or stooping.	1	2	3
g) Walking **more than one kilometre**.	1	2	3
h) Walking **half a kilometre**.	1	2	3
i) Walking **100 metres**.	1	2	3
j) Bathing or dressing yourself.	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	YES	NO
a) Cut down on the **amount of time** you spent on work or other activities.	1	2
b) **Accomplished less** than you would like.	1	2
c) Were limited in the **kind** of work or other activities.	1	2
d) **Had difficulty** performing the work or other activities (for example, it took extra effort).	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a) Cut down the **amount of time** you spent on work or other activities.	1	2
b) **Accomplished** less than you would like.	1	2
c) Didn't do work or other activities as carefully as usual.	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(circle one)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

No bodily pain 1
Very mild 2
Mild 3
Moderate 4
Severe 5
Very severe 6

8. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?

(circle one)

Not at all 1
A little bit 2
Moderately 3
Quite a bit 4
Extremely 5

9. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u> -

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a) Did you feel full of life?	1	2	3	4	5	6
b) Have you been a very nervous person?	1	2	3	4	5	6
c) Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d) Have you felt calm and peaceful?	1	2	3	4	5	6
e) Did you have a lot of energy?	1	2	3	4	5	6
f) Have you felt down?	1	2	3	4	5	6
g) Did you fell worn out?	1	2	3	4	5	6
h) Have you been a happy person?	1	2	3	4	5	6
i) Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time..... 5

11. How TRUE or FALSE is each of the following statements for your?

(circle one number on each line)

	Definitely True	Mostly true	Don't Know	Mostly False	Definitely False
a) I seem to get sick a little easier than other people.	1	2	3	4	5
b) I am as healthy as anybody I know.	1	2	3	4	5
c) I expect my health to get worse.	1	2	3	4	5
d) My health is excellent.	1	2	3	4	5

You have now finished the SF-36 Health Survey.

SECTION 1: DEMOGRAPHICS/TREATMENT HISTORY

1. Client Sex: Male ☐ Female ☐

2. Client DOB: __ / __ / __

3. Transferring from another programme? Yes ☐ No ☐ ➔ SKIP TO Q. 5

4. Transferring from: _____

5. How many times have you been on a methadone programme in the past? _____ ➔ GO TO Q. 9
(TRANSFERS: DO NOT INCLUDE CURRENT PROGRAMME)

6. How old were you when you first entered a methadone programme? _____

Thinking about the last time you were on a methadone programme…
(TRANSFERS: THIS QUESTION REFERS TO THE TIME BEFORE CURRENT PROGRAMME)

7. How long were you on that programme? _____(Yrs) _____(Mths)

8. How long has it been since you left that programme? _____(Yrs) _____(Mths)

9. What other sorts of treatment options have you tried in the past?

- ☐ None
- ☐ Detoxification
- ☐ Counselling
- ☐ Therapeutic community
- ☐ Narcotics Anonymous
- ☐ Family/Whanau Support
- ☐ Other

NOTES

10. If appropriate ask for the following information:

	Number of admissions	Last admission date
Detoxification	_____	__ / __ / __
Therapeutic community	_____	__ / __ / __

SECTION 2a: DRUG USE

This section is about your use of drugs and alcohol **DURING THE PAST 4 WEEKS**.
6. On average, how often have you used the following drugs in the past four weeks?

	AVERAGE LEVELS OF USE <u>In the past 4 weeks</u> *(Circle one number only for each drug type)*						**NOTES**
DRUG TYPE	**Nil**	**Once per week or less**	**More than once a week**	**Daily**	**2-3 times daily**	**4 or more times daily**	
a. MST's	0	1	2	3	4	5	
b. Homebake	0	1	2	3	4	5	
c. Heroin	0	1	2	3	4	5	
d. Other Opiates/Opiate Substitutes eg poppies, codeine, digesic, temgesic, illicit methadone	0	1	2	3	4	5	
e. Cannabis	0	1	2	3	4	5	
f. Amphetamines	0	1	2	3	4	5	
g. Hallucinogens	0	1	2	3	4	5	
h. Cocaine	0	1	2	3	4	5	
i. Tobacco	0	1	2	3	4	5	

SECTION 2A: DRUG USE (CONTINUED)

BENZODIAZEPINES

What was your average use of benzodiazepines in the past four weeks? *Circle One Only*

0	1	2	3	4	5
Nil use	Once per week or less	More than once a week	Daily	2-3 times daily	4 or more times daily

Average daily benzodiazepine dose

Benzodiazepine Type	mgs

Full dose information not available ☐

What is your source of benzodiazepines?

Legally prescribed ☐ 1

Street sources ☐ 2

Both ☐ 3

ALCOHOL

On an average week, how many standard drinks have you had over the past 4 weeks?

(NOTE: Only approximate information is required) *Circle One Only*

	0	1	2	3	4	5
Female	Nil	1-14	15-21	22-28	29-35	36+
Male	Nil	1-21	22-28	29-35	36-42	43+
Drinking at or below recommended "safe" levels.			*Drinking at or above recommended "safe" levels*			

<u>Warning:</u> Your personal "safe" level may be much lower depending on your liver function, whether or not you use other drugs or medications, or whether you have received a recent head injury for example. Consult a staff member or your GP for more information.

Standard Drink Guidelines

300 mls (half pint) beer

or

100 mls (small) wine

or

50 mls sherry/liqueur

or

30 mls (single) spirits

SECTION 2B : DRUGs Used Today

My next question is about the drugs you have used today.

1. Thinking back to this morning, please list all the drugs you have used today and the amounts you used.

Drug	Amount Used	Time Taken
1.		
2.		
3.		
4.		
5.		
6.		

SECTION 2c : Continuous Opiate use

Now I am going to ask you about your pattern of opiate use over time.

These questions are about your use of <u>all</u> opiates as a group (i.e. heroin, morphine, codeine, MSTs, homebake, street methadone and poppies).

1. When was the last time you had a *day* without using any opiates? ....._____
2. When was the last time you had a *week* without using any opiates? ....._____
3. When was the last time you had a *month* without using any opiates? ...._____
4. What has been your longest period of non-use? ....._____

General Comments on Continuity of Opiate Use

SECTION 3 : OPIOID DEPENDENCE CHECK LIST

These questions are about your overall use of opiate drugs (i.e. heroin, morphine, codeine, MSTs, homebake, street methadone and poppies) **during the last 12 months**.

PLACE A TICK TO THE RIGHT HAND SIDE OF ITEMS IF THE CLIENT RESPONDS WITH A "YES".

		TICK
1.	Have you found that you need to increase the amount of opiates you use to get the effect you want?	☐
2.	Have you found that when you stop taking opiates for a while, you begin to get withdrawal symptoms ("hanging out")? (ASK CLIENT TO DESCRIBE SYMPTOMS. DSM IV).	☐
3.	Have you found that you have been taking opiates in larger amounts than you intended? OR have you found that you have used opiates for longer than you first intended?	☐
4.	Have you found yourself wanting to cut down or stop all the time but have not been able to?	☐
5.	Have you found yourself spending a great deal of your time trying to obtain (score) opiates?	☐
6.	Have you missed out on important work, social or recreational activities because of your opiate use?	☐
7.	Have you had any ongoing physical or emotional problems that you think have been caused by opiate use, or made worse by opiate use?	☐

NOTE TO THE INTERVIEWER:

ANSWERING "YES" TO THREE OR MORE OF THESE QUESTIONS INDICATES THAT THE CLIENT MOST LIKELY MEETS THE DSM IV CRITERIA FOR "OPIOID DEPENDENCE" - A REQUIREMENT FOR ENTRY ONTO A METHADONE PROGRAMME IN NEW ZEALAND. IF YOU ARE NOT ENTIRELY SATISFIED THAT THE CLIENT MEETS THREE OR MORE CRITERIA SEEK THE ADVICE OF YOUR SUPERVISOR.

SECTION 4: HIV / HCV Risk taking assessment

These questions are about the way you use drugs, and your recent sexual behaviour. I emphasise again that any information that you give me is completely confidential.

DRUG USE

1. How many times have you hit up (i.e. injected any drugs) in the last month?

   Hasn't hit up 0
   Once a week or less.....1
   More than once a week 2
   (but less than once a day)
   Once a day.....3
   2-3 times a day 4
   More than 3 times a day.....5

   IF NO NEEDLE USE GO TO Q. 7

2. How many times in the last month have you used a needle **after** someone else had already used it? (INCLUDE SEXUAL PARTNERS)

   No times 0
   One time 1
   Two times.....2
   3-5 times.....3
   6-10 times.....4
   More than 10 times.....5

3. How many different people have used a needle **before** you in the last month?

   (INCLUDE SEXUAL PARTNERS).

   None 0
   One person 1
   Two people.....2
   3-5 people.....3
   6-10 people.....4
   More than 10 people.....5

4. How many times in the last month has someone used a needle after you have used it? (INCLUDE SEXUAL PARTNERS).

   No times.....0
   One time 1
   Two times 2
   3-5 times 3
   6-10 times 4
   More than 10 times 5

5. How often, in the last month, have you cleaned needles before re-using them ?

   Doesn't re-use 0
   Every time.....1
   Often 2
   Sometimes 3
   Rarely.....4
   Never 5

6. Before using needles again, how often in the last month did you use bleach to clean them?

   Doesn't re-use 0
   Every time.....1
   Often 2
   Sometimes 3
   Rarely.....4
   Never 5

For advice on safe needle use or access to clean needles call:

ADIO

7a Maidstone St, Ponsonby, Auckland

Tel. 376-8519 (10 am to 10 pm)

Emergency after hours 021-683-932

SEXUAL BEHAVIOUR

7. Have you worked in the sex industry in the last month?

   Yes ☐ 1 No ☐ 0

8. How many people, have you had sex with in the last month?

   (INCLUDING CLIENTS IF APPROPRIATE).

   None 0
   One person 1
   Two people.....2
   3-5 people.....3
   6-10 people.....4
   More than 10 people.....5

   IF "NONE" ABOVE
   SKIP TO QUESTION 12 - RE: SEXUAL HEALTH

9. How often have you used condoms when having sex with your regular partner(s) in the last month?

   No reg. partner/
   No penetrative sex.....0
   Every time 1
   Often.....2
   Sometimes 3
   Rarely 4
   Never 5

10. How often did you use condoms when you had sex with casual partners in the last month?

    No casual partners/
    No penetrative sex.....0
    Every time 1
    Often.....2
    Sometimes 3
    Rarely 4
    Never 5

11. [IF APPROPRIATE] How often have you used condoms when you have been paid for sex in the last month?

    No paid sex/No penetrative sex ... 0
    Every time..... 1
    Often 2
    Sometimes..... 3
    Rarely..... 4
    Never..... 5

12. Have you ever had a sexual health check-up?

    Yes ☐ 1 No ☐ 0

    IF "NO" SKIP NEXT QUESTION.

13. When was your last sexual health check-up?

    More than a year ago 0
    In the last year..... 1
    In the last nine months..... 2
    In the last six months 3
    In the last three months..... 4
    In the last month 5

For advice on sexual health issues in Auckland call **Sexual Health Services**:

Central: 307-2885
South: 263-7604
West: 836-0838
North: 443-2544

SECTION 5: SOCIAL SITUATION

These next few questions concern the social aspects of your life (things like family, jobs, friends, etc.).

1. Do you have any children in your care at the moment ? Yes ☐ 1 No ☐ 0

   IF "NO" SKIP TO NEXT PAGE (Q.4)

2. How many children are in your care? ☐

3. What are the children's ages?

(One box for each child's age)

1	2	3	4	5	6	7	8	9	10

4. How many different places have you lived in over the last six months?

One 0
Two 1
Three 2
Four 3
Five or more 4

5. How much of the last six months have you been unemployed?

All of the time 4
Most of the time 3
Half of the time 2
Some of the time 1
None of the time 0

6. How many different full-time jobs have you had in the last six months?

One 0
Two 1
Three 2
Four or more 3
None 4

7. How often in the last six months have you had conflict with your relatives?

Very often 4
Often 3
Sometimes 2
Rarely 1
Never 0
N/A 0

8. How often in the last six months have you had conflict with your partner(s)?

Very often 4
Often 3
Sometimes 2
Rarely 1
Never 0
N/A 0

9. How often in the last six months have you had conflict with your friends?

Very often 4
Often 3
Sometimes 2
Rarely 1
Never 0
N/A 4

10. How often in the last six months have you been worried that someone might be violent towards you?

Very often 4
Often 3
Sometimes 2
Rarely 1
Never 0

11. How often in the last six months has someone been violent towards you?

Very often 4
Often 3
Sometimes 2
Rarely 1
Never 0

12. About how many close friends would you estimate that you have? (INCLUDE PARTNER)

None 4
One 3
Two 2
Three 1
Four or more.....0

13. When you are having problems, are you satisfied with the support you get from your friends?

Very satisfied 0
Satisfied.....1
Reasonably OK 2
Not satisfied 3
Very unsatisfied 4
N/A.....0

14. About how often do you see your friends?

Very often.....0
Often.....1
Sometimes.....2
Rarely 3
Never 4
N/A 4

15. How many of the people you socialise with now have you known for more than 6 months?

None 4
Less than half 3
About a half.....2
More than half.....1
All of them 0
N/A.....4

16. How much of the last six months have you been living with anyone who injects opiates?

All of the time.....4
Most of the time.....3
Half of the time.....2
Some of the time.....1
None of the time 0

17. How many of the people you socialise with are now IV users? (INCLUDE PARTNER)

None.....0
Less than half.....1
About a half 2
More than half 3
All of them.....4

18a. Many people who use opiates find themselves involved in crime of one sort or another.

Have you ever been involved in crime (including illegally buying or selling drugs)?

Yes ☐ 1 No ☐ 0

IF "NO" SKIP LAST QUESTION

18b. Compared with when you first came on this methadone programme, has your involvement in crime increased, decreased stayed the same or stopped?

Increased ☐ 1
Decreased ☐ 2
Stayed the same ☐ 3
Stopped ☐ 4

SECTION 6: URINE TEST AT ASSESSMENT

(Admission Assessment Only)

1. Sample provided: __ / __ / __

TICK THOSE DRUGS DETECTED IN URINE AT ASSESSMENT.

Opiate (not specified)	☐
Heroin	☐
Morphine	☐
Codeine	☐
Methadone	☐
Propoxyphine	☐
Benzodiazepine	☐
Amphetamine	☐
Cocaine	☐
Phencyclidine (PCP)	☐

Client First Name: _____

Client Last Name: _____

Client Number: _____

Medical Officer: _____

METHADONE ASSESSMENT MEDICAL INTERVIEW

Developed by

Auckland Regional Alcohol & Drug Services

All information in this form is protected as per the Health Information Privacy Code 1994

MEDICAL ASSESSMENT

Medical History

1. Name of Usual GP: _____

2. Past Medical Problems (include hospitalisations): _____

_____

_____

_____

3. History of STD's: ☐ Yes ☐ No
   - What diagnosed? _____
   - Where diagnosed? _____
   - When diagnosed? _____

4. Hep C : ☐ Not Tested ☐ Tested +ve ☐ Tested -ve
   - Where diagnosed? _____
   - When diagnosed? _____

5. Hep B : ☐ Not Tested ☐ Tested +ve ☐ Tested -ve
   - Where diagnosed? _____
   - When diagnosed? _____

6. HIV: ☐ Not Tested ☐ Tested +ve ☐ Tested -ve
   - Where diagnosed? _____
   - When diagnosed? _____

7. Past Psychiatric History: ☐ Yes ☐ No
   - Diagnosis? _____
   - Hospitalised? _____

8. History of Self-Harm: ☐ Yes ☐ No
   - Suicide? _____
   - Methods? _____

9. History of Overdose: ☐ Yes ☐ No
   - Deliberate? ☐ Yes ☐ No

10. Allergies:

_____

_____

_____

_____

11. Other Meds:

_____

_____

_____

_____

MEDICAL ASSESSMENT (CONT.)

Review of Systems (Taken Directly from the OTI Health Scale)

These questions are about your health. I am going to read out a list of health problems. Please answer "Yes" if you have had any of these problems over the last month.

General		**Tick**
1.	Fatigue / energy loss	____
2.	Poor appetite	____
3.	Weight loss / underweight	____
4.	Trouble sleeping	____
5.	Fever	____
6.	Night sweats	____
7.	Swollen glands	____
8.	Jaundice	____
9.	Bleeding easily	____
10.	Bruising easily	____
11.	Teeth problems	____
12.	Eye / Vision troubles	____
13.	Ear / Hearing troubles	____
14.	Cuts needing stitches	____

Injection Related Problems		**Tick**
1.	Overdose	____
2.	Abscesses / Infections	____
3.	Dirty hit (made feel sick)	____
4.	Prominent scarring/bruising	____
5.	Difficulty injecting	____

Cardio/Respiratory		**Tick**
1.	Persistent cough	____
2.	Coughing up phlegm	____
3.	Coughing up blood	____
4.	Wheezing	____
5.	Sore throat	____
6.	Shortness of breath	____
7.	Chest pains	____
8.	Heart flutters/racing	____
9.	Swollen ankles	____

Genito-urinary

		Tick
1.	Painful urination	____
2.	Loss of sex urge	____
3.	Discharge from penis/vagina	____
4.	Rash on or around penis/vagina	____

Gynaecological

(in the last few months)

		Tick
1.	Irregular period	____
2.	Miscarriage	____

Musculo-skeletal

		Tick
1.	Joint pains/stiffness	____
2.	Broken bones	____
3.	Muscle pain	____

Neurological

		Tick
1.	Headaches	____
2.	Blackouts	____
3.	Tremors (shakes)	____
4.	Numbness / Tingling	____
5.	Dizziness	____
6.	Fits / seizures	____
7.	Difficulty walking	____
8.	Head injury	____
9.	Forgetting things	____

Gastro-intestinal

		Tick
1.	Nausea	____
2.	Vomiting	____
3.	Stomach pains	____
4.	Constipation	____
5.	Diarrhoea	____

MEDICAL ASSESSMENT (CONT.)

Description of Client

1. Weight: _____ (kilos) (estimated)
2. Height: _____(cm's) (estimated)
3. Eye Colour: _____
4. Hair Colour: _____
5. Distinguishing Features: _____
6. Track Marks (Where): _____
7. Scars (Describe): _____
8. Blood Pressure: _____

Check

1. CVS_____
2. RS_____
3. Abdominal_____
4. Neurological Exam_____

Blood Tests

1. Haemoglobin: _____
2. MCV: _____
3. Liver Function - ALT: _____
   - AST: _____
   - GGT: _____
4. HBsAg: _____
5. Hep B sab: _____

MEDICAL ASSESSMENT (CONT.)

General Comments Following Medical Assessment:

Signed:_____