Using mental health outcome measures to support quality assurance of DVA funded PTSD programs

Andrea Phelps
Clinical Psychologist

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What are DVA funded PTSD programs?

Group based treatment for veterans with PTSD and co-morbid problems

Cohorts of around 8 veterans

Program models include inpatient, residential, day program and regional outreach – average 28 days

Program participants predominantly Vietnam veterans but also older (WWII and Korean) and younger (peacekeepers, Iraq and Afghanistan) veterans

Peaked in 2000/2001 with 19 programs throughout Australia treating over 500 veterans p.a. Currently 12 programs treating around half that number
Core program features

- Multidisciplinary team
- Cognitive behavioural orientation
- Primarily group program
- Individual therapy
- Education and support to veterans partners
- Attention to discharge planning and follow-up

Program content areas

- Psychoeducation about PTSD and its treatment
- Trauma focussed work
- Symptom management – anxiety, depression, anger
- Substance abuse and addictive behaviours
- Interpersonal, problem-solving and communication skills
- Physical health and lifestyle issues
- Relapse prevention
Measuring program outcomes: Dimensions and instruments

PTSD and common co-morbid mental health problems

- PTSD: PTSD Checklist (PCL; Weathers et al. 1993)
- Depression and anxiety: Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)
- Anger: Dimensions of Anger Reaction (DAR; Novaco, 1975)
- Alcohol: Alcohol Use Disorders Identification Test (AUDIT; Saunders et al. 1993)

Marital relationship
Abbreviated Dyadic Adjustment Scale (ADAS; Sharpley & Rogers 1984; Spanier 1976)

Quality of life
Brief World Health Organisation Quality of Life Instrument (WHOQoL-Bref; WHOQOL Group, 1998)
Measuring program outcomes: Data collection protocol

- Participants complete self-report instruments at intake, discharge, 3 month follow-up and 9 month follow-up.

- Protocols submitted to ACPMH for data entry and analysis

Use of treatment outcome data in the quality assurance process

1. Individual program’s outcomes compared to national averages - measure of accountability

2. Individual program’s outcomes compared to their previous outcomes – feedback on service initiatives/changes

3. Disparities between a program’s outcomes and national outcomes – service development opportunity
### Measure Mean National Program Intake 3 9 mth mth Effect size Intake 3 9 mth mth Effect size

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### Other sources of information about quality

- Program staff description of treatment model and practices
- Qualitative feedback from veterans and partners
- Feedback from key stakeholders
  - Veterans and Veterans Families Counselling Service (VVCS)
  - ex-service organisation representatives
  - DVA
How information is used to promote quality

Examples:

- minimal reduction in avoidance symptoms – examine program’s approach to exposure therapy
- High scores on alcohol use at intake and follow-up – review alcohol assessment, preparation and intervention, check veterans’ feedback

Maintaining quality during a time of change:
Declining demand

![Graph showing number of participants treated by financial year and state](image)
Maintaining quality during a time of change:

Declining demand

Potential threats to quality

- Pressure to fill a cohort
- Retention of experienced staff

Meeting the needs of younger veterans and peacekeepers

Increasing access and uptake
Pathways to care study (Hawthorne et al. 2004)

- 30% veterans recently compensated for a mental health disability not receiving treatment
- Of those who have sought help 20% dissatisfied
- 42% of peacekeepers report they have stopped treatment
Maintaining quality during a time of change:

Meeting the needs of younger veterans and peacekeepers

More effectively targeting needs

- Anecdotally, peacekeepers present with more anger, social disruption and substance use issues

More severe PTSD (clinician rated), and higher anger (veteran rated) at intake

- Smaller changes in PTSD (0.5 vs 0.7), anger (0.3 vs 0.5) and depression (0.3 vs 0.5) following treatment

Maintaining quality during a time of change:

Greater emphasis on community based care

Quality assurance mechanisms don’t extend to range of community based service providers

Move to self-assessment model of PTSD QA

- Components - access and targeting, clinical processes, treatment model, operational management, outcome monitoring
- Program self assessment combined with outcome data, participant and stakeholder feedback
- Applicable across treatment providers
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