TOP of the form?

The controversial Treatment Outcomes Profile (TOP) form has been in use – and under scrutiny – for five years. Now, TOP has been suggested as a crucial measure for Payment by Results. New research by **Ira Unell** and colleagues reveals a continuing lack of staff confidence in the TOP.

Launched in 2007, TOP was designed to be used for a variety of purposes. It was intended as a clinical tool with individual patients/clients to measure progress and identify areas of improvement, areas where more work needed to be done and as an aid to care planning. It was hoped that agencies would use TOP to improve services. Finally, it was thought that TOP could be used for commissioning purposes: "At local, regional and national levels, the information will be used to monitor the effectiveness of services and partnerships" (NTA).

From the start, however, the enterprise was controversial. Despite a long and extensive pilot programme to develop TOP, many within the drug treatment field felt that it was flawed. In an article in *Druglink* (Over the TOPS?, Vol. 22 Issue 5, September/October 2007), Diane Taylor quoted sources within the treatment field and research workers questioning in particular the validity of the section on offending and criminal involvement. This has been the most controversial of the sections because it requires the treatment worker to ask the patient/client to disclose recent offending committed within the last 30 days, including "shoplifting, drug selling, theft from or of a vehicle, other property theft or burglary, fraud, forgery and handling stolen goods, committing assault or violence".

While the NTA recommends that the treatment worker should provide assurances that the information provided will be completely confidential, drug users might be sceptical, especially those who attend a criminal justice treatment service where the staff of that service is required to report to the court on the behaviour of the client.

By 2009, after two years of experience with TOP, practitioners were even more sceptical of the validity of TOPs data, again especially about the offending and criminal involvement section. One study by Luty and colleagues analysed the TOPs forms of 200 individuals who attended their drug treatment service. They found that 67% of their sample declared no paid income to fund their Class A drug use. Their average spending for Class A drug use alone was £988 per month (not to mention the spending on Class B & C drugs and alcohol). The authors concluded that "the section on crime in the TOP form is unreliable and completely invalid."

General Practitioners were at the forefront of protests about the use of the section on offending and criminal involvement. In a response to the NTA on TOP, Linda Harris, on behalf of the Royal College of General Practitioners, welcomed the effort to record outcomes on treatment but drew attention to the section on offending and criminal involvement. She argued that General Practitioners do not trust the "quality of the information being reported back from patients in relation to the crime question…". She further argued that some localities now record a complete cessation of criminal activity recorded from TOP. This is hardly credible as a result of treatment.

In 2010, a team from Leicester Community Drug and Alcohol Service and Leicester University conducted a survey to measure the confidence of those who provide drug treatment and record the data in the TOP questionnaire.

The survey was conducted in the East Midlands. The treatment agencies were NHS community drug teams, a shared care prescribing service and two criminal justice drug treatment teams. They were experienced drug workers (average length of time in the field was over 9 years). There were 158 people who could have completed the survey and 106 actually responded (67%).

The TOP questionnaire is divided into four sections: substance use, injecting risk behaviour, crime, and health and social functioning. This is followed by questions asking clients to rate psychological health, physical health and quality of life on a 20 point scale. There are also questions about work, education and housing.

The first question of our survey asked, "To what extent do your clients/patients answer the following TOP questions honestly?" followed by each of the four sections. The respondent was asked to mark on a 10 point scale ranging from "Clients answer honestly" to "Clients answer dishonestly".

The second question asked "To what extent do you think that the answers you record on each of the TOP sections represent a true picture of your client's behaviour?" Again, the respondent was asked to mark on a 10 point scale which started with "Answers record true picture" to "Answers do not record true picture", for each of the four sections.

The third question asked the respondent to rate the usefulness of TOP (again using a line which was marked between "Useful" to "Not Useful" on a 10 point scale) for assessing new clients, for monitoring client progress, as a way of assessing agency effectiveness for commissioning purposes, and as a way of assessing a particular form of treatment.

The last two questions asked what

proportion of clients appear to trust that the answers they provide in TOP will be kept confidential and what proportion of drug treatment staff in their own or other treatment agencies fill in the TOP form without specifically asking their clients? For these two questions, there was a line to be marked ranging from 0% to 100%.

The results are shown in the tables below:

QUESTION 1	*Client answers honestly = 10* *Client answers dishonestly = 0*
Substance Use	Average = 6.2
Injecting risk behaviour	Average answer = 6.2
Crime	Average answer = 2.1
Health and social functioning	Average answer = 6.5

QUESTION 2	*Answers record true picture = 10* *Answers do not record true picture = 0*
Substance Use	Average answer = 5.5
Injecting risk behaviour	Average answer = 5.5
Crime	Average answer = 2.0
Health and social functioning	Average answer = 5.4

QUESTION 3	*Useful = 10* *Not useful = 0*
For assessing new clients?	Average answer = 4.5
For monitoring client progress?	Average answer = 4.5
As a way of assessing agency effectiveness for commissioning purposes?	Average answer = 3.3
As a way of assessing a particular form of treatment?	Average answer = 3.0

QUESTION 4	
What proportion of your clients appear to trust that the answers they provide in TOP will be kept confidential?	58.1 %

QUESTION 5	
What proportion of drug treatment staff in your own or other treatment agencies fill in the TOP form without specifically asking their clients?	56.6 %

SUMMARY CATEGORIES	**No. of answers in that category**
Terminate TOP entirely	12
Drop or change questions on criminality	21
Less frequent use of TOP	5
Shorten time scale (currently up to 4 weeks) asking patients/ clients to remember drug/alcohol use	5
Keep it as it is, useful measure of progress	3

We also asked: 'How would you improve TOP?'. Out of 106 questionnaires, 68 made at least some comment on how TOP could be improved. There were a wide range of answers, but they could be categorised under the following headings:

Treatment workers who complete the TOP questionnaires seem to have low levels of confidence in the questionnaire and its validity. Indeed, a surprisingly high proportion (56.6%) of treatment workers believe that other treatment workers complete the questionnaires without even asking their clients.

Overall, the level of confidence in the honesty of the answers from clients were modest in three of the four sections (substance use, injecting risk behaviour, and health and social functioning), scoring between 6.4 – 6.5 out of a possible 10. As you might expect, the fourth section (criminality) scored much lower – 2.1 out of a possible 10.

The same pattern emerged when respondents were asked if each of the sections portrayed a true picture of their client's behaviour. Three of the four sections scored between 5.4 and 5.5 out of a possible 10. The fourth section – criminality – once again achieved a very low score: 2.0 out of a possible 10.

TOP was designed with a number of purposes in mind. It was intended to help clinicians measure their clients'/ patients' progress, to assess the treatment effectiveness of individual agencies and to test the effectiveness of different types of treatment. The East Midlands survey suggests it has failed to convince the majority of those who provide the treatment and collect the data that it is a worthwhile exercise.

With confidence so low among those who collect and record TOP data, it should be asked if the time and cost of collecting this data is worth the effort. Valid and reliable outcome data is crucial in measuring the effectiveness of treatment. TOP is a first attempt to collect this data across drug treatment agencies in England. It has failed to gain the support of workers across a sample of agencies and the meaning of the results of TOP data is open to question.

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