Chapter 1 : DMRI - Drugs Misuse Research Initiative

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For clinically significant change to occur, a second criterion - reliable change - which takes account of measurement error must also be achieved. The population recruited here, university and NHS staff, is not representative of the general population. There is an overrepresentation of females, which could be accounted for by a combination of factors: However, the patterns of reported drinking and dependence scores are as expected. The gender imbalance is immaterial since calculations are made separately for males and females. Dependence scores varied with different levels of reported substance use: In the clinical sample the SSQ pre-treatment mean is high, indicating that even the clinic population has a general satisfaction with their social circumstances, thus making clinically significant change less likely. Dissatisfaction was most commonly expressed with two SSQ items, employment and finance. When applied to the clinical population, the LDQ scores showed most improvement, which might be expected in an addiction treatment service. Individuals with an alcohol problem improved more than those with heroin or other drug problems; drinkers were predominantly male Where methadone was the main problem drug typically started as a substitute prescription , change was much less likely than for other substances across all three measures. We looked at outcomes by age group and by episode of treatment - the results are varied and difficult to interpret. Deterioration is more common for CORE and SSQ, which is a well-recognised phenomenon clinically - abstinence or control over substance misuse exposes individuals to the consequences of their substance use and this is commonly expressed as psychological distress and dissatisfaction with social circumstances. These negative experiences reflect the real world and should not necessarily be taken as symptoms of mental illness. Newly abstinent drinkers or, more commonly, drug users may also experience a psychological insecurity which, again, may be expressed in high CORE and low SSQ scores. The precision of short scales is limited and is a tradeoff against the benefits of tools suitable for routine clinical use 19 - shorter scales need more careful interpretation of results. The dimensions chosen have consistently been evidenced as important elements of addiction. Dependence is a predictor of treatment outcomes 20 , 21 which tends to reduce early in treatment, 22 and so dependence works well as a feedback tool for practitioners. Equally, social satisfaction is important: The NIHR had no role in the study design, collection, analysis or interpretation of the data, writing the presentation, or the decision to submit the poster for dissemination. The Local Research Ethics Committees reference: Humpreys K, McLellan T. A policy-oriented review of strategies for improving the outcomes of services for substance use disorder patients. Evaluating patient-based outcome measures for use in clinical trials. Health Technol Assess ; 2: National Institute for Mental Health in England. Assessment and measuring treatment outcomes. In Responding to Drug Misuse: Clinical Descriptions and Diagnostic Guidelines. Addict Res Theory ; 9: Alcohol Advisory Council of New Zealand, Evaluation of the Leeds Dependence Questionnaire. J Child Adolesc Subst Abuse ; 8: An evaluation of the Dartmouth Assessment of Lifestyle Inventory and the Leeds Dependence Questionnaire for use among detained psychiatric inpatients. Addict Behav ; Validation of the Social Satisfaction Questionnaire for outcome evaluation in substance use disorders. Psychiatr Bull ; The construction, development and testing of a self-report questionnaire to identify social problems. Psychol Med ; Connell J, Barkham M. Jacobson NS, Truax P. J Consult Clin Psychol ; Methods for defining and determining clinical significance of treatment effects: Response rates and response bias for 50 surveys of paediatricians. Health Serv Res ; Couns Psychother Res ; Patient predictors of alcohol treatment outcomes: J Subst Misuse Treat ; Gibbs L, Flanagan J. Prognostic indicators of alcoholism treatment outcome. Int J Addict ; The nature and measurement of change in substance dependence [PhD thesis]. University of Leeds, The process of recovery from alcoholism. Comparing functioning in families of alcoholics and matched control families. J Studies Alcohol ; Social support and relapse: The long-term course of treated alcoholism. Predictors and correlates of year functioning and mortality. J Stud Alcohol ; Social and community resources and long-term recovery from treated and untreated alcoholism. Network therapy for

addiction: Am J Psychiatry ; Social relationships and abstinence from cocaine in an American treatment sample. A meta-analysis of predictors of continued drug use during and after treatment for opiate addiction.

Chapter 2 : Motivational Dialogue: Preparing Addiction Professionals for Motivational - Google Books

Management of alcohol detoxification Duncan Raistrick (Raistrick et al, , with the usual treatment for the mental illness.

Unit costs of healthy and social care. Calculation of quality adjusted life years in the published literature: Randomised controlled trial of general practitioner intervention in patients with excessive alcohol consumption. Academy of Medical Sciences: Alcohol abuse, cognitive impairment and mortality among older people. Annals of Internal Medicine Brief interventions for alcohol problems: Characteristics, diagnosis and treatment of alcoholism in elderly patients. Factors associated with hypothermia in patients admitted to a group of inner city hospitals. Comparison of consumption effects of brief interventions for hazardous drinking elderly. Substance Use and Misuse Costs and cost effectiveness of treatment as usual in drug misuse services. Leeds Addiction Unit; Low identification of alcohol use disorders in general practice in England. Brieg physician advice for alcohol problems in older adults. Effectiveness of brief alcohol interventions in primary care populations Cochrane Library. Effectiveness of brief interventions to reduce alcohol intake in primary health care populations: Effectiveness of physician-based interventions with problem drinkers: Canadian Medical Association Journal Effects of brief counselling among male heavy drinkers identified on general hospital wards. Drug and Alcohol Review Geriatric substance use disorders. Med Clin North Am Efficacy of brief interventions for hazardous drinkers in primary care: The effectiveness and cost-effectiveness of screening and stepped care interventions for alcohol use disorders in the primary care setting. A Guide for Practitioners. Health service use and mortality among older primary care patients with alcoholism. The Report of an Inter-departmental Working Group. London, Department of Health; National Alcohol Research Project: Older patients with at risk and problem drinking patterns: New developments in brief interventions. Outcomes at 1 year and 5 years for older patients with alcohol use disorders. Journal of substance abuse treatment Arch Intern Med Royal College of Physicians: Can the NHS afford it? A iem short form health survey: Construction of scales and preliminary tests of reliability. Screening and referral for brief intervention of alcohol misusing patients in an Accident and Emergency Department: Screening for problem drinking in older people: Aging Ment Health Opportunistic screening for alcohol use disorders in primary care: Cost-effectiveness of treatment for alcohol problems. Effectiveness of treatment for alcohol problems. The Drinking Problems Index: An instrument to assess alcohol related problems amongst older adults. The general health of older people and their use of health resources. The quest for a new diagnostic instrument. Hazardous drinkers in the accident and emergency department: Emergency Medicine Journal Treatment programmes for aging alcoholics. In Alcohol and aging Edited by: Beresford T, Gomberg E. What about the elderly? Accident prevention and risk taking by elderly people: The need for advice.

Chapter 3 : Home | Duncan Raistrick

Moreover, treatment as usual the treatment system and more people stay on substitute is often used as the control in trials of novel treatments. prescriptions. In order to contain the demand, commissioners are moving away from open ended treatment packages to time limited packages.

The main difference is the proportion of Pacific Nation clients. It is recognised that the clients studied are not representative of all potential clients. Many potential clients do not access services as they are currently provided. It is possible that it will be similarly useful for non-presenting people but this will have to be tested separately. Understanding the similarities and differences increases the ability to interpret the statistical results about the LDQ. Looking at the available demographic data, the populations are very close in terms of average age Turning to the results of the various instruments used, the similarities are surprisingly strong, especially for the LDQ and SADQ measures of dependence. The greatest difference was in the level of social problems reported, with the Leeds Addiction Unit study population reporting a higher level of social problems Raistrick et al , p. The results of the SF Health Survey are included as a general contribution to national data on different populations. As time progresses it will be possible to make a series of useful comparisons. The main advantage of this approach is that validity can be assessed for the LDQ under realistic circumstances - i. This is appropriate given that we never validate a measuring instrument - merely the use to which it is put Nunnally , p. An attempt was made to match clients to therapists by both ethnicity in terms of the three broad categories used and gender. They were all trained in the use of the psychometric research instruments, the Survey Evaluation Checklist, and the other administrative tasks associated with the project - for example, introducing the project to clients, collecting consent details, etc. A brief presentation was also given on the potential uses of the LDQ in assessment and treatment planning. The first requirement arose out of the need to have an accurate measure of substance intake to validate the LDQ against. Measurement of retrospective alcohol intake is more developed than that for other substances. Retrospective measurements of other substances are much more problematic. It is recognised that the language requirement has important implications for the generalisability of the research. The LDQ has only been validated for English-speaking members of the three ethnic groups studied. Additional research will be needed if validation is to be extended. The subsequent two requirements, sobriety and the absence of physical or psychological impediments, were included for practical reasons, and the final requirement, membership of one of the three main ethnic groups listed, was included because these were the three groups for whom research is being conducted. An analysis of the client assessment records of RADS for the last year showed that any attempt to break this grouping down into specific nationalities - e. Samoan, Tongan etc - or to focus on just one Pacific ethnic group would make it impractical to reach the sample sizes required for statistical testing within an acceptable timeframe. This was especially true when the numbers of women within each Pacific nationality were examined. There would be insufficient Samoan women, for example, to allow an analysis of gender as well as of ethnicity. It was decided, therefore, to group the various Pacific nationalities for the purposes of this research. It was felt that this would not significantly undermine the validity of the research on the LDQ in the same way as it might for other types of research - e. Each group had both male and female subjects. Clients were then asked to read an information sheet and sign a consent form. Data collection Standard practice is for clients arriving at RADS to be given an assessment interview by the counsellor assigned to them. This was the point at which clients were given the assessment package. In some cases, the package was delivered in a second or subsequent session; in other cases, staff experimented with having clients complete portions of the package at home - most commonly the Timeline Follow-back technique TLFB. Following this, staff helped clients to construct a retrospective picture of their alcohol consumption using the TLFB. Specially developed techniques are used to enhance recall. The calendar and standard drinks conversion chart were modified for the New Zealand context. In addition to the assessment data collected, the following client details were collected: With the exception of the SF Health Survey, these were the instruments 23 used by the Leeds Addiction Unit in its research refer to the discussion of convergent validation for an explanation of the reasons for using the SF in preference to the

General Health Questionnaire GHQ. Firstly, because the SADQ is the more established and widely tested instrument of the two. The authors of the SDS recently noted the need for further research on its validity in clinical settings Gossop et al , p. Secondly, because the SDS was not designed to measure dependence on alcohol where existing alternatives are available Gossop et al , p. This is a critical point given that this research, as was discussed earlier, will be restricted to clients who have alcohol as one of the substances for which they are seeking treatment. This restriction arises out of the need to have an accurate measure of substance intake to validate the LDQ against. It was reasonable to expect that the instruments used would be sufficiently valid for the New Zealand populations included in the study. In general terms, the use of the instruments described for assessing the LDQ was considered acceptable by the following people consulted: During the assessments, counsellors observed client experiences of the LDQ. To assist with this process, counsellors were issued a survey evaluation checklist see following appendices. The following questions were included: Have you come to dislike any questions? A survey makes it possible to focus attention on the issues most relevant to validity rather than on those which pose practical problems for survey administrators Fowler , p. At the end of the session, counsellors asked clients a few questions about their experience of the LDQ. These included a question about the perceived helpfulness of the tool. The final data collection task was to gather staff feedback on the clinical use of the LDQ. It was decided to use a focus group methodology for this purpose. This methodology is an appropriate way of gathering research data when applied properly Krueger , p. Two focus group meetings were organised to document and explore the way in which the LDQ was used in assessment and treatment planning during the assessment interview. Although focus groups have traditionally been comprised of people unknown to each other, this is not essential Krueger , pp. Having said this, however, it is recognised that the use of colleagues, some of them known to each other, can raise some special issues Krueger , pp. In this case, none of these were expected to be significant. The staff involved were all comparable in terms of their hierarchical position within the organisation at the time of the research at least and they were selected from a variety of different work teams See Krueger , p. The role of the assistant moderator was to tape the meetings and take notes See Krueger , pp. At the end, participant verification of any conclusions drawn about utilisation was sought see Krueger , p. Immediately after the sessions, debriefing occurred between the moderator and assistant moderator to capture first impressions see Krueger , p. As with the focus group discussions themselves, these debriefing sessions were taped and transcribed see Krueger , p. Encouraging the use of standard surveys asking clients about health, drug use, and so on is one way of achieving this. Before introducing a survey it is important that it is tested in New Zealand. A survey which works for American clients may not work for New Zealanders. Key issues will be validity - does the survey actually measure dependence - and usefulness for client assessment. To take part you must have experienced some problems with alcohol not necessarily severe and be able to read English. This is your invitation to take part in this research. If you do not take part this will not negatively affect your treatment or any other relations with the service. If you change your mind you can ask to take part later. If you do want to take part all you have to do is fill in five surveys: This should take around 45 minutes. Your counsellor will then briefly discuss the results of the Leeds Dependence Questionnaire with you. Your confidentiality is completely protected. The information you provide will be entered into a secure computer so that the usefulness of the Leeds Dependence Questionnaire can analysed. After that, because the information you provide may be useful to you and your counsellor in the future, your interview material will be stored in your personal file which is stored strictly according to the Privacy Act No one will be able to identify you, or your information when the research findings are produced. This is because the research report will be focusing on group results, not on individuals. If you are interested in the results or wish to know more about the research, please phone Dr. If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, Auckland, phone Thank you for expressing interest in the Leeds Research Project! Included in this package is an information sheet describing the project for you to read first. If you still feel comfortable about being involved, please sign the consent form on the next page. In this booklet are four questionnaires which ask you about your alcohol use, your general health, and problems you may have experienced as part of your drinking. Simply follow the instructions for each questionnaire. Most of the

questions involve putting a circle around different answers to questions. Sometimes you may find that the options offered in the questions do not quite match your experience are seem to be for someone older or younger than you. In this case, just choose the answer that is most like your experience. What I do with the booklet when I have finished? Bring the booklet in with you when you see your counsellor. If you do not want to fill this out by yourself, no problem. You can always fill it out at the beginning of your appointment with your counsellor if you like. Name of patient or subject: Witness name please print Witness signature Date Consent obtained by:

Chapter 4 : Cost and cost effectiveness of treatment as usual in drug misuse services - CORE

Contents: Policy responses to the drugs problem / Susanne MacGregor -- The focus on crime and coercion in UK drugs policy / Karen Duke -- Drug-taking and its psycho-social consequences / John Macleod -- Treatment as usual / Duncan Raistrick.

Dale Watson et al. Alcohol misuse is a major cause of premature mortality and ill health. Although there is a high prevalence of alcohol problems among patients presenting to general hospital, many of these people are not help seekers and do not engage in specialist treatment. Hospital admission is an opportunity to steer people towards specialist treatment, which can reduce health-care utilization and costs to the public sector and produce substantial individual health and social benefits. Alcohol misuse is associated with other lifestyle problems, which are amenable to intervention. It has been suggested that the development of a healthy or balanced lifestyle is potentially beneficial for reducing or abstaining from alcohol use, and relapse prevention. The aim of the study is to test whether or not the offer of a choice of health-related lifestyle interventions is more acceptable, and therefore able to engage more problem drinkers in treatment, than an alcohol-focused intervention. This is a pragmatic, randomized, controlled, open pilot study in a UK general hospital setting with concurrent economic evaluation and a qualitative component. Potential participants are those admitted to hospital with a diagnosis likely to be responsive to addiction interventions who score equal to or more than 16 on the Alcohol Use Disorders Identification Test AUDIT. The main purpose of this pilot study is to evaluate the acceptability of two sorts of interventions healthy living related versus alcohol focused to the participants and to assess the components and processes of the design. Qualitative research will be undertaken to explore acceptability and the impact of the approach, assessment, recruitment and intervention on trial participants and non-participants. The effectiveness of the two treatments will be compared at 6 months using AUDIT scores as the primary outcome measure. There will be additional economic, qualitative and secondary outcome measurements. Development of the study was a collaboration between academics, commissioners and clinicians in general hospital and addiction services, made possible by the Collaboration in Leadership in Applied Health Research and Care CLAHRC program of research. CLAHRC was a necessary vehicle for overcoming the barriers to answering an important NHS question â€" how better to engage problem drinkers in a hospital setting. Despite their poten- and ill health. Europe has the highest number of tial, healthy lifestyle approaches have received the least alcohol-related disabilities in the world with alcohol ac- emphasis in the alcohol treatment literature [19]. Alco- This study will investigate whether a healthy lifestyle hol is a contributing factor to over 60 types of disease approach may be more acceptable, and therefore more and injury [2]. Providing specialist treatment for prob- effective, in a non-help seeking population of problem lem drinkers can reduce health-care utilization and costs drinkers than an explicit emphasis on changing drinking to the public sector and result in substantial individual behavior alone. A standard treatment for alcohol prob- health and social benefits []. The majority of these people are motivational enhancement, behavior change techniques not help seekers for their alcohol problem, nor are they and social support [20]. The healthy living intervention identified or referred by hospital staff for specialist ad- that will be compared to iSBNT has been developed on diction treatment [7,8]. The hospital admission is an op- the basis of the same mechanisms with the aim of chan- portunity for identification and treatment, and the Royal ging drinking behavior through change in one or more College of Physicians recommends screening for alcohol lifestyle domains. Also alcohol misuse The study is a pragmatic, parallel-group, randomized, con- tends to be overlooked when it is not the presenting trolled pilot study in which an alcohol-focused interven- problem [10,11]. Hospital staff have expressed reluctance tion is compared with a healthy living intervention for to use the hospital admission opportunity to intervene problem drinkers identified in a general hospital setting. A gagement and retention in psychological therapies [12]. Typically, acceptability has been inferred from dropout rates, rather than being explored in its own right. Staff Aims of the study are more likely to undertake screening and an interven- To explore through qualitative interviews, the accept- tion if they believe it to be acceptable to patients [13]. Research, while somewhat contradictory, To explore through qualitative interviews, the accept- suggests that a

key issue here is how such questioning is ability of the healthy living intervention and the alcohol- undertaken. For instance in one study, while a majority focused intervention in a population of non-help seeking of patients reported preferring computerized feedback problem drinkers and alcohol-dependent patients pre- about their drinking over personalized feedback from senting in the hospital setting. This suggests that vention in their impact on drinking problems. Marlatt and colleagues [16,17] suggest the develop- To evaluate the level of treatment retention amongst ment of a healthy or balanced lifestyle is potentially participants randomized to the two interventions, based beneficial for reducing alcohol use, abstaining from alco- on numbers attending first and subsequent sessions. A population-based, To explore the acceptability and feasibility of postal as- pre-randomized, controlled study of the effectiveness of sessment instruments at 6- and month follow-ups. No Yes Consents to be interviewed in hospital? Yes Willing to be interviewed? Hypothesis drinking behavior in a non-help seeking population of The hypothesis is that the healthy living intervention problem drinkers. Preparatory studies in our program of Watson et al. The in-reach team Patients scoring 15 or less on the AUDIT who have are responsible for recruiting and providing treatment to been admitted with an alcohol-related problem are given the study participants. All patients admitted to the target a leaflet containing information on units, stopping or re- wards are considered potential participants if they meet ducing alcohol intake, the support available at a local the eligibility criteria. The leaflet is based on Patients are eligible if they: Department of Health advice and evidence from previ- ous trials including the Screening and Intervention â€" are admitted to one of the hospitals with a diagnosis Programme for Sensible Drinking trial [22]. This infor- Disorders Identification Test AUDIT mation is used to collate eligibility and non-eligibility or â€" are aged 18 years and over males and females non-participation information, as well as providing AUDIT â€" are willing and able to give written informed scores, reason for admission, age and gender for prevalence consent data and to inform future studies. Patients are excluded if they: Consent procedure Potential participants are provided with a verbal explan- â€" have received specialist treatment with a primary ation of the study and a copy of the PIS. The PIS outlines focus on alcohol in the past 6 weeks the purpose of the study, the proposed interventions, â€" have no fixed abode that is, are not available for study processes and time commitment required for both follow-up treatment and follow-up assessments. For those agreeing â€" are currently serving a sentence in prison or have to participate, written consent is obtained and a baseline outstanding legal issues likely to lead to questionnaire is completed. An additional PIS gives infor- imprisonment mation and asks for consent to participate in the qualita- â€" have a mental or physical illness likely to preclude tive element of the study. Within each consent pair, one therapist is trained to deliver the alcohol- â€" are unable to take part in either intervention using focused intervention and the other trained to deliver the spoken English or are unable to self-complete the healthy living treatment. Each participant is randomized validated English language outcome measure tools such that they have a This Study procedures approach is based on previously obtained opinions from Identification service users stating that continuity of care is important All patients admitted to the selected wards are consid- to them. Should one of the therapists in the pair not be ered potential participants. The hospital in-reach team available due to illness or similar reasons, the participant identifies patients who have an alcohol-related diagnosis is allocated to a therapist within a different pair at the or a reason for admission that suggests a possible point of randomization. Participants are randomized by alcohol-related diagnosis, which is thought to be respon- a secure remote computer service run by the fully regis- sive to addiction interventions. Choice is a key variable in the study intervention. The partici- pant is encouraged to enlist the help of someone who is Intervention content concerned about them and broadly shares their behavioral Both interventions are delivered in four sessions using goals. At the first session, the target domains are agreed. This number of sessions be pursued. The participant is then asked in which order has been determined using evidence from the UK Alco- they wish to pursue the domains and a goal is set for the hol Treatment Trial UKATT , which suggest optimal first one. Behavioral plans are made for achieving the goal attendance is achieved over four sessions [24]. At Each intervention consists of four sessions of 30 to 45 the second session, progress towards the previously set minutes each, delivered one to two weeks apart, over a goal is explored and reviewed and the next domain is maximum period of 8 weeks. Sessions for either arm can addressed in the same way. Where the behavioral

goals for a domain home or at a mutually agreed suitable alternative loca- are not achieved, the therapist and participant decide tion as is current practice for the Hospital In-Reach whether to repeat or to move on to the next domain. Drinking eral goal or make a behavioral resolution, and encouraging does not have to be one of the chosen domains. Feedback from the participant on their performance need for medical treatment of a physical condition, or sur- allows them to review the behavioral goals together with gical or psychiatric treatment that does not preclude deliv- the therapist. Motivational dialogue is used to elicit behav- ery of the study interventions. If after their participation in ior change by helping clients explore and resolve ambiva- the research is complete, a participant wishes to continue lence and facilitate treatment goal-setting [20]. It has a strong evidence base in UK cedures and the practices and techniques of each interven- clinical trials and is increasingly commonly taught and tion, followed by supervised practice of study treatments practiced in the UK addiction field. It contains exclu- until deemed competent. Once deemed competent, phasis on structure and skill rehearsal. Additional training is given to apply new skills in their own environment. Home- on the study protocol process, documentation completion work is used to implement new practice and facilitate and obtaining informed consent. The participant is encouraged to recruit a supportive Blinding network of concerned others, who will help the partici- Due to the nature of the interventions in this study, pant to implement behavior change and develop new blinding of participants and therapists to allocated treat- lifestyle habits inconsistent with drinking. The network ment is not possible. However, baseline data were col- is encouraged to make plans to cope with relapse risks lected prior to randomization and follow-up data will be and actual relapse, providing support for each other collected by postal questionnaires: The healthy living intervention, which is also a behav- ioral approach, combines behavior change in up to three Qualitative data chosen domains that contribute to overall health. Seven Although assessing the components and processes of the options from which the participant chooses three are diet, design is an important feature of this pilot, the main pur- exercise, drinking, smoking, medication concordance, drug pose is to evaluate the acceptability of the interventions to Watson et al. Social satisfaction is mea- and non-participants, exploring their thoughts and feel- sured using the Social Satisfaction Questionnaire SSQ , ings concerning their identification as a problem drinker a validated eight-item scale found to be a suitable out- in the hospital context and how this status compares to come measure in people with substance use disorders their own perceptions of their drinking behavior. This also covering social domains that are likely to be important allows us to explore the impact of hospitalization and re- to, and engage, service users in treatment [31]. The interviews with the non-participants also probe tioning are measured using the Clinical Outcomes in Rou- reasons for not participating in the study. The EQ-5D is a standard- of 10 to 15 individuals from each arm of the trial who ized measure of health status developed by the EuroQol have participated in part or all of their treatment ses- Group in order to provide a simple, generic measure of sions. These four measures are taken at baseline, and change and how formal elements of the interventions 6 and 12 months post randomization. Participant use of In addition, the therapists delivering the interventions health services, other alcohol services outside the study, will be interviewed once recruitment is well under way public services and criminal justice services is assessed to ask them about their experience of identifying people through service use-questions at baseline, and 6 and 12 with alcohol issues and how patients responded to their months post randomization. We will use utility values approach. The therapists will be provided with an infor- based on societal values using the York tariff [35]. Recruitment rates are presented in three tiers: Where permitted, interviews are audio- acceptability. Quantitative assessment of the acceptabil- recorded. In addition, a second researcher will independ- ity of the postal follow-up questionnaires is assessed by ently perform a thematic analysis on a sub-sample of return rates and completion rates. Qualitative assess- transcripts, with discussions taking place to develop an ment of any issues regarding questionnaire completion agreed coding framework. Therefore, the All follow-up data are collected by postal question- AUDIT score at 6 months post randomization has been naire at 6 and 12 months post randomization with postal designated as the main patient outcome and is also mea- reminders sent 2 and 4 weeks after initial correspond- sured at 12 months post randomization, whilst the ence. In the event of a participant failing to complete Watson et al. Interviews are digitally recorded where consent is given , fully transcribed and imported into Atlas. Thematic analysis will All treatment sessions are video-recorded the partici- be used to

identify themes by their frequency, intensity pant is not visible for the purpose of supervision in and extensiveness, a technique described by Braun and order to prevent practitioner drift. These are inde- Clarke [38]. However, due to an unexpected delay in the ing intervention at 6 months. Model checking will be performed to en- Sample size calculation sure that the model is a good fit for the data. If necessary, Originally the trial had planned to use 6 therapists over transformations will be used to improve model fit. It was estimated from current case loads that 4 therapists can screen a maximum of patients in 6 Secondary statistical analyses months. Of these,

Chapter 5 : - NLM Catalog Result

Duncan Raistrick et al. undertook preparation for detoxiï¬•cation as usual. Prepa- treatment variables and gives a 95% conï¬•dence interval.

This version is available at http: Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided: For more information, including our policy and submission procedure, please contact the Repository Team at: Prospectively estimating cost effectiveness The specific objectives were: Describing a methodology for routinely costing treatment To describe treatment as usual in a range of different drug misuse service providers. Further development of treatment process and outcome measures To estimate the range of costs of treatment as usual. Many individuals now in treatment have come through the Criminal Justice System. One can reasonably assume from this that, on the In estimating cost effectiveness it was assumed that treatment one hand, there are significant numbers in treatment who was the major determinant of improved outcome. It can be are not looking to change their drug using behaviour but, argued that such an assertion would require comparison with on the other hand, retaining these people in treatment is a no treatment control group. However, given the weight of likely to deliver significant Criminal Justice System savings. Moreover, treatment as usual the treatment system and more people stay on substitute is often used as the control in trials of novel treatments. In order to contain the demand, commissioners are moving away from open ended treatment packages to time limited packages. Little is known about what actually happens when service users are referred to service provider agencies and engage in Few UK studies have attempted to estimate the cost of substance treatment. Most research into treatment outcomes compares misuse services. Where structured psychosocial treatments gold standard interventions against a novel treatment. This have been compared, trials have found few differences is a legitimate way to test the optimal delivery of particular between the specific treatments under investigation. In the interventions but says little about the diversity of activity that UK Alcohol Treatment Trial the average cost of Motivational is found in agencies across the UK. However, both delivered similar cost supported by a substantial investment of government funds effectiveness and both fell within the NICE benchmark of in drug misuse treatment agencies. In the National Treatment Outcome Research Study treatment activity, and how the investment impacts on health NTORS methadone maintenance programmes were found and social care and the criminal justice system. Cost and Cost Effectiveness studies need to be interpreted with great caution. At first sight, there appears to be a huge diversity in both costs and outcomes. However, on closer inspection, it can be seen that costs have been estimated in different ways. Contributory variables are differences in accounting methods, differences in service user characteristics, and differences in the aims of treatment. Study participants were in less good general and The study planned to recruit service users from seven psychological health than the general population: The cohort was followed up at 6 against 0. At 6 month follow up there were statistically significant morbidity. The seven participating agencies were intentionally chosen 5. The intention was that participating agencies should form a reasonable cross section of UK service providers. The range used in previous projects. The costings method took account of health, social, and criminal justice costs NICE excludes criminal justice costs. The range of interventions that agencies said they provided and the cost of these varied markedly. All of the service providers were found to have made a positive response to help seekers and all delivered 8. Broadly for this study was 0. The size of the treatment 9. At follow-up participants completed a Treatment effect was similar to that found in other areas of healthcare Perceptions Questionnaire. The mean score for perceptions and within the NICE approved cost limit. The key findings about the staff was 2. A third of service users added comments 1. The seven participating service providers were different about their treatment and these were overwhelmingly in terms of: The size and ethnic mix of their catchment areas At some level all agencies expressed benefits from participating in this service orientated research. There is The service user characteristics scope for improving service delivery by providing training The size of the staff group and staff skills mix in the delivery of

interventions, by routine monitoring of The role of the agency within the local treatment process and outcomes, provision of routine supervision of practice and review of service costs. Agencies tended to under-estimate their non attendance rates. This may not be surprising given the level of substance misuse including University of York: Christine Godfrey, Professor of a very high prevalence of smokers but the implication is Health Economics; Steve Parrott, Principal Investigator and that engagement in treatment will, at least in the short term, Research Fellow in Health Economics; Veronica Morton, result in increased use of health resources. It is recommended that: With thanks to front line clinical and administrative staff and to service users in all participating agencies who were It is not possible to know how representative of UK treatment always helpful and keen to support the project. It is likely, therefore, that findings from the study are generalisable. Without the 12 month follow-up it is Initiative phase two: The views expressed in this difficult to know how many people coming into treatment report are those of the authors and not necessarily those of will successfully exit and how many will reinstate substance the Department of Health. It cannot be assumed that good outcomes will be sustained particularly where substitute prescribing has been instrumental in CONTACTS bringing about early improvement. Dr Duncan Raistrick The study has shown that it is possible to undertake good Consultant Addiction Psychiatrist quality research in drug misuse services. All participating Leeds Addiction Unit agencies expressed a belief that there had been benefits Leeds from the collaboration. Agencies cited improved data Duncan.

Chapter 6 : LDQ New Zealand report by Duncan Raistrick - Issuu

Duncan Raistrick, Gillian Tober, Christine Godfrey, Steve Parrott, Steve Lui, Adele Loftus, Sarah Maddox, Christina Cheney, Emma Bates. Cost and Cost Effectiveness of Treatment as Usual in Drug.

Chapter 7 : Measuring clinically significant outcomes - LDQ, CORE and SSQ as dimension measures of ac

Specific treatments account for the smallest element of the addiction treatment outcome variance, and effective delivery of these treatments requires the prerequisites of organizational support and therapist competence. Psychosocial interventions have different parts to play in opioid substitution.

Chapter 8 : Holdings : Responding to drug misuse : | York University Libraries

Policy responses to the drugs problem / Susanne MacGregor --The focus on crime and coercion in UK drugs policy / Karen Duke --Drug-taking and its psycho-social consequences / John Macleod --Treatment as usual / Duncan Raistrick [and others] --Care co-ordination in drug treatment services / Tim Weaver [and others] --The effect of waiting for.