issue 3 summer 2000

DRUG & ALCOHOL FINDINGS

linking
practice
to research
research
to practice

what works
what doesn't
what could be
done better

DRUG & ALCOHOL FINDINGS

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DRUG & ALCOHOL FINDINGS

Objectives To improve Britain's response to drug and alcohol problems by disseminating practice-relevant evaluation findings on the effectiveness of interventions including prevention, community safety and treatment.

Readers Workers involved in a specialist or non-specialist role in interventions addressing drug or alcohol problems in the United Kingdom, including drug and alcohol service practitioners, planners, managers, and commissioners, those whose responsibilities include these functions, and researchers working in these fields.

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Editor Mike Ashton Drug & Alcohol Findings, 10 Mannock Road, London N22 6AA • *Telephone and fax* 020 8888 6277 • *E-mail* findings@mashton.cix.co.uk.

Editorial Board Mike Ashton Editor • Sue Baker Alcohol Concern • Dr David Best National Addiction Centre • Annette Dale-Perera DrugScope.

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Has he found the key to prevention in schools?

Enthusiast and sceptic

No togetherness over policy guide

Education's uncertain saviour

A 20-year series of studies of a relatively unknown US programme kept hopes alive that schools can prevent drug use. The record is impressive – but is it enough to salvage drug education's prevention credentials?

by **Blaine Stothard**
& **Mike Ashton**

Blaine Stothard is an independent consultant in health education. He can be contacted at blaine@healthed.demon.co.uk.
Mike Ashton is the editor of *Drug and Alcohol Findings*.

This issue's 'key study' spanned two decades, starting modestly in 1980 with a study in two schools and peaking in 1995 with an investigation involving over 3500 pupils from 56 schools followed up for six years. What all the studies had in common was a secondary school drug prevention curriculum called Life Skills Training. Behind the curriculum and the research is the psychologist Professor Gilbert Botvin of Cornell University's Institute for Prevention Research. For drug prevention, the importance of his work cannot be overstated. In any research-based guide, including official advice in the UK,[1] it features as the most solid justification for school lessons about drugs, a breach in the otherwise largely justified pessimism.

Understanding Dr Botvin's work – its strengths, its limitations, and its trans-Atlantic transferability – is an essential starting point for anyone planning school-based drug prevention. After reading this article, you will at least be towards the end of that starting point.

Twenty years of research

Dr Botvin's curriculum crystallised in the late 1970s when some Europeans too were querying the prevention utility of the drug education of the time. They shared an awareness of a growing literature showing that 'straight' information, warnings of dangers, and appealing to moral considerations, did not prevent drug use.

Against this negative backdrop, Gilbert Botvin was struck by findings from the University of Houston showing that smoking could be dramatically delayed by lessons based on an understanding of *why* children started to smoke.[2] Houston's tactics remain fundamental: pupils were taught the skills to resist social pressures and media influences, and enabled to compare their own smoking with that of their peers, correcting misconceptions that 'everyone is doing it' – the 'normative fallacy'.

> *In official UK advice* ***Life Skills Training*** *provides the most solid justification for school lessons about drugs*

Dr Botvin joined in the wave of research which followed. His approach was distinctive, teaching smoking resistance skills to adolescents within a broader programme fostering general social and personal skills and addressing the psychological factors – poor self-esteem, social anxiety, lack of confidence – which might impede exercise of those skills. From the start he called it "Life SkillsTraining".[3]

It has grown and diversified, but the curriculum's core remains as it was in the 1970s; the intervening 20 years can be seen as an extraordinarily in-depth investigation of a single approach. Here we concentrate on the studies which did most to illuminate the programme's worth, first among white middle class pupils, and then among America's ethnic minority urban poor.

In Middle America

Among America's white middle class, the high point for Life Skills Training came with a study which in 1995 published outcome data collected six years after baseline, an unprecedented follow-up period. Previous research had found that older pupils, teachers, and health educators could all profitably deliver the lessons, and that booster sessions in the years following the intensive seventh grade input helped maintain the impact. The new study was intended to test the real-world applicability of Life Skills Training and to do so over a longer time scale.

Conducted in 56 schools in New York state, the study started with nearly 6000 seventh grade (age 12–13) pupils.[4] Schools with comparable smoking rates were randomly allocated either to continue as normal (the control condition) or to 30 Life Skills sessions over three years delivered after one of two training inputs; teachers attended a one-day workshop with Botvin's team and received follow-up support, or were simply given a two-hour training video with instructions.

By the end of the three years of lessons, how often pupils smoked cigarettes, used cannabis or got drunk (but not drinking as such) were slightly but significantly lower in Life Skills pupils than controls.[5] However, the reporting of these results was badly flawed. An account of outcomes for whole schools rather than individual pupils was relegated to a footnote, yet this was the more appropriate analysis since schools, not pupils, were randomised to the conditions. It still came up with some significant results, but now drunkenness was unaffected and only the fully trained teachers reduced cannabis use. Still, the cuts in smoking may be considered worthwhile on their own.

In both analyses results from a quarter of the Life Skills pupils (and six whole schools) were excluded because they had received under 60% of the intended teaching, *yet no similar adjustment could be made for the control schools*, creating a potentially serious source of bias favouring Life Skills.[6] Outside a research context even more pupils might receive incomplete teaching; evaluations which exclude them risk divorce from reality.

Detailing six-year outcomes, the final report rectified these faults, yet still found worthwhile and statistically significant impacts, particularly on heavy, more damaging forms of drug use.[7] Life Skills had curbed the growth in regular smoking among the now roughly 18-year-old youngsters; most notably, 12% of controls

Acknowledgements
We are grateful to Professor Botvin and to his colleague Cara Jean McCarthy for providing a portfolio of research papers, to Professor Skager of the University of California, Los Angeles, for allowing us to reprint his seminar presentation, and to Dr Joel Brown of the Center for Educational Research and Development for his assistance. We are also grateful to Professor Skager, Dr Niall Coggans of the University of Strathclyde's Institute for Biomedical Sciences, and Vivienne Evans of DrugScope, for comments on this article in draft. Though they have all enriched it, they bear no responsibility for the final text.

smoked a pack a day compared to just 9% of the Life Skills pupils whose teachers had been video-trained. Though this is the recommended method, reductions in heavy smoking among pupils whose teachers had been personally trained were not significant. The 3% reduction in weekly cannabis use (6% versus 9% in controls) also failed to reach significance. Drinking as such was unaffected, though fewer Life Skills pupils admitted frequent drunkenness. The most convincing curbs were in regular use of two or more of alcohol, tobacco or cannabis. For example, compared to controls half as many Life Skills pupils (3% versus 6%) smoked, drank and used cannabis weekly.

The findings suggest that teachers can take the Life Skills manual and materials and end up with worthwhile, lasting curbs on regular smoking and multi-drug use and perhaps also problem drinking, curbs which if they outlast the teenage years could help preserve physical health throughout life.

Across the poverty/race divide

Life Skills Training was first developed and tested among mainly white middle class pupils from intact suburban and rural families. Exploratory studies suggested that basically the same curriculum amended only in technical (reading level) and cosmetic ways (illustrative examples and role-play situations) would be suitable for America's black and Latino urban poor.

Thoughnot the largest study of these groups, the most intriguing was a small-scale trial which tested the amended curriculum against a 'culturally focused' one designed from the ground up for ethnic minority pupils. Using techniques similar to Life Skills, it sought to affect the same skills and psychological variables over the same number of sessions with the same seventh-grade age group.

But instead of whole classes, it "targeted high-risk students" using a group counselling format.[8] Stories ancient and modern told how "heroes" had used life skills to overcome feelings of alienation and hopelessness similar to those afflicting America's urban poor. There was no place for drug-related knowledge, not even the data Life Skills used to correct the 'normative fallacy'. The two skills curricula were compared with a much shorter information-only intervention which did tackle the 'normative fallacy'.[9]

There were two key questions. First, would the longer interventions perform better than the information-only option? If not, it would be a strong indication that, for these pupils, skills teaching was a waste of resources. In fact, the skills-based approaches did add value, curbing the growth of drinking and drunkenness over the two years of the study as well as intentions to drink in future, though cannabis use and intentions were unaffected.[10]

The second issue was whether the major overhaul produced better results than the adaptation. On all the current drinking measures, the culturally focused curriculum did outperform Life Skills Training – *even though no drug knowledge was imparted* other than incidentally.

The data appeared to vindicate Dr Botvin's focus on improving the skills and psychological variables thought to underlie drug use – a result tarnished only by the fact that he was unable to show most actually *had* improved. The culturally focused curriculum's failure to increase self-esteem and self-efficacy is particularly disappointing, given that his own work highlights these as risk factors among the urban poor.[11]

Variables which did change as expected were how often pupils said they assertively refused drugs in a range of situations and their preferences for risktaking. Along with stronger anti-drinking attitudes, the analysis suggested that these underpinned at least part of the programmes' impacts on current and anticipated drinking.

Methodological defects included the fact that just 60%f the 757 seventh-graders who supplied baseline data could be re-surveyed two years later. The information-only sample also included far more Latinos, a third as many black pupils and many more intact families than the skills interventions samples. If black pupils respond better to skills interventions – or to *any* intervention – than Latinos, this alone could account for their apparent superiority. Lastly, *schools* were allocated to conditions whose outcomes were analysed by *pupil.*

A later study tested the amended Life Skills curriculum against control schools' usual teaching.[12] The racial mix of the samples differed in the *opposite* direction to the previous study, providing a partial check on whether this had been a source of bias. Shortly after the intervention, compared to controls Life Skills pupils evidenced less frequent drinking, smoking and cannabis use, as well as drinking less alcohol on each occasion and reporting fewer episodes of drunkenness. Effects were not large, but did coalesce into a 9% reduction (15% v. 24%) in the numbers using all three drugs at least once a month.

Golden Bullets

Essential practice points from this article

- Life Skills Training can result in **lasting curbs** on regular smoking, multi-drug use and problem drinking which could help preserve physical health throughout life.
- However, there is **insufficient consistency** in the findings to be confident that implementing Life Skills **will** cut legal or illegal drug use, only that it can do and has done, most consistently in relation to smoking.
- Keys to the programme's successes seem to be its intensity, use of booster sessions, **interactivity**, emphasis on **skills**, and its potential for delivery by peer leaders.
- Even the best school programmes usually only achieve **delays** and **small reductions** in the extent and intensity of drug use. Nevertheless, thousands of lives could saved at lower cost than many medical interventions.
- Use prevention effects are gained by correcting misconceptions about the normality and acceptability of drug use, improving drug-related knowledge and assertiveness in using drug refusal skills, and heightening anti-drug attitudes – all **drug-specific variables**. General skills and psychological variables seem less relevant.
- Whether any such programme can prevent **drug problems** is an open question; for Life Skills the evidence is strongest in relation to heavy smoking and drinking to intoxication.
- Normalisation of drug use creates a need for approaches which do not assume that personal and social **deficits** lead to drug use and for research and programmes permitted to adopt **harm reduction** objectives.
- To prevent serious drug problems, rather than universal programmes it may be more cost-effective to **target the few** potentially affected pupils with individualised help while still providing drug **education** to all.
- British schools could profitably adapt elements of Life Skills' teaching **methods** and **content**, especially as much of it could double as a general personal and social skills curriculum, but the full programme is unlikely to be considered appropriate or to be implemented.

The evidence is far from conclusive, but it does seem that Life Skills Training transfers across America's poverty/racial divide, producing worthwhile impacts on smoking and drinking which can nevertheless be improved on by programmes thoroughly tailored to the pupils, their social environments and cultural traditions.

Gaps in the evidence

Though methodologically advanced,[13] the Life Skills studies suffered from problems common to much prevention evaluation, and their thoroughness exposed weaknesses which might otherwise have remained hidden. Here we deal with issues pertinent to the studies as a whole.

Does it really work?

Most fundamentally, does the accumulated evidence really prove Life Skills Training reduces drug use? Some eminent voices are unconvinced.

Dennis Gorman, then of the US Rutgers University Center for Alcohol Studies, has argued that in successive evaluations the goalposts were shifted, in two ways.[14] First, what counts as success was reformulated to match the positive findings, perhaps most questionably in claims based on the use of several drugs when results for each individual substance were disappointing. Second, positive outcomes have been manufactured by excluding pupils who received incomplete teaching.

He also raised the issue of what counts as scientific proof. A varied heap of positive findings is used to back the generalised claim that Life Skills Training 'works', while the probably equally large heap of negative findings is discounted. Yet no amount of individual findings can prove the programme is and will be effective, only that it *has* been effective in certain ways at certain times with certain groups. Equally, at other times, in other ways, and in other circumstances, it has *not* been shown to have been effective.

Though valid, such criticisms perhaps understate the difficulty of proving effectiveness without excessive controls which undermine real-world relevance; perhaps it is justifiable to place more weight on the hard-won positives. And there is at least one relatively consistent stream of positive findings – with respect to smoking, the programme's original target. This may not be accidental (*Cracks in the theory*).

The bottom line? There is insufficient consistency in the findings to be confident that implementing a Life Skills programme *will* cut drug use, only that it *can* do and has done, especially in relation to smoking.

How does it work?

Confidence that something *has* worked is greatest when we can see *how* it worked – that a push at one end of a line of cards really did cause the last one to fall when we can see the intervening cards tumbling. Without this chain of 'mediating variables', there is always the suspicion that something else caused the outcome.

Professor Gilbert J. Botvin: developed Life Skills Training and researched its impact for over 20 years.

Life Skills' intervening cards derive from its theory of how drug use develops and how it intervenes in that development. For this theory, the most disappointing results are the curriculum's inconsistent impacts on the skills and psychological variables through which it is supposed to influence drugtaking.

Evidence is strongest for the knowledge and skills most closely related to drug use, which also tend to be those susceptible to classroom teaching: students' awareness of how (ab)normal drug use is and of its social acceptability; drug-related knowledge; knowing about social skills as opposed to practising them; and assertiveness in refusing drug offers as opposed to general assertiveness. Among the remainder, the most consistently documented is increased anti-drug attitudes.

In contrast, significant impacts have generally not been seen on psychological variables such as self-esteem and self-confidence nor on *general* skills like assertiveness and decision-making. The problem is that these go to the heart of what makes Life Skills distinctive – locating drug-specific content within "a large context of social skills kids need to navigate the minefield of adolescence".[15]

Showing that some mediating variables changed in ways *thought* to reduce drug use is not enough to prove these actually *caused* the reduction. The two Life Skills studies which tested causality more directly found evidence of a role for assertiveness in using drug refusal skills, anti-drug attitudes, drug-related knowledge, and correcting youngsters' misconceptions about the normality and social acceptability of drug use – all drug-specific variables.[16, 17]

Several explanations have been advanced to account for these failures. Those which leave the underlying theory intact either do not account for all the findings or cast doubt on positive as well as negative findings. A more damaging explanation is that skills and psychological variables not directly related to decisions about drugtaking have little impact on those decisions, perhaps why a review found programmes which focus on drug-related skills about as effective as broader programmes.[18] However, as in Dr Botvin's studies, the yardstick was drug use;

What is Life Skills Training?

Life Skills Training's publishers describe it as a "substance abuse prevention/competency enhancement program designed to focus primarily on the major social and psychological factors promoting substance use/abuse".[65] It consists of 15 45-minute classes implemented either in the equivalent of year seven (ages 11-12) or year eight in British schools, followed by ten and then five booster sessions in the next two years.

Specific aims are to:

- provide the skills to resist social (peer) pressures to smoke, drink and use drugs;
- help develop self-esteem, self-mastery, and self-confidence;
- enable children to effectively cope with social anxiety;
- increase knowledge of the immediate consequences of substance use.

The lessons cover: **personal self management skills** (solving problems, managing emotions, achieving goals); **social skills** (communication, interacting with others, boy/girl relationships, assertiveness); **drug-related information and skills** (knowledge, attitudes, normative expectations, skills for resisting drug offers, media influences, advertising pressures to use drugs).

Rather than a supplier of facts, the teacher's major role is that of skills trainer or coach, imparting skills through instruction, demonstration, role play, practice, extended practice in the form of homework assignments, feedback, and social reinforcement. In its information content the curriculum concentrates on the facts adolescents react to most readily, such as the immediate negative results of drug use and how many of their peers use drugs, rather than long-term health consequences. Materials include a detailed teacher's manual, a student guide, and audio cassettes with relaxation exercises.

http://www.lifeskillstraining.com. COLOURS NOT AS IN ORIGINAL.

http://dare-america.com. COLOURS NOT AS IN ORIGINAL.

Life Skills Training has a far better research record yet remains undersold compared to programmes such as D.A.R.E. – contrast the opening pages from their respective web sites.

ignoring general variables and skills might leave pupils vulnerable to drug *problems*.

The usual methodological problems

Remaining methodological shortcomings are endemic in schools-based prevention research. Though comonly done, analysing outcomes in terms of *pupils*, but allocating *schools* to control and experimental conditions, risks mistakenly finding an intervention successful. However, the reverse – shrinking the sample down to a handful of schools – risks missing an effect when there really was one.

Often control and Life Skills groups differed substantially; too little is known about children's development to be able to adequately adjust for this uneven playing field. Typically Life Skills Training has been compared against 'business as usual' in control schools, an unknown quantity. If this is ineffective or worse, then Life Skills had a head start.

Certainly in some (and probably most) studies data was collected by the research team who presumably also analysed the results. We are not told whether they knew which pupils had or had not received Life Skills Training; 'blinding' to such knowledge is an important safeguard against bias. Lastly, Dr Botvin has tested his own programme and benefited from its sales and from associated training; independent evaluation is always preferable.[19]

A way to cut drug-related harm?

Putting methodological queries to one side, there remains the issue of the *practical* as opposed to the statistical significance of the findings; in particular, whether Life Skills Training can cut drug problems as well as drug use, and whether the degree to which it can do so warrants the investment.

Mixed findings on problematic use

Life Skills Training's accolades have been received from assessors whose yardstick was use prevention rather than problem reduction, and its formally documented drug use outcomes have been limited to tobacco, alcohol and cannabis. For many the more pertinent issue is whether reduced use translates into less damaging use of the same or of other substances.

Whether Life Skills Training prevents heavy use of its target drugs is obscured by the reporting of a frequency index conflating the range of use levels. Where frequency has been specified, results have been mixed for regular or recent use of tobacco, and though rates of drunkenness have been reduced,[20] heavy drinking as such has not and neither has frequent cannabis smoking.[21]

Nevertheless, especially with respect to smoking, any reduction in use is a health bonus. Dr Botvin has estimated that nationwide the small % of youngsters prevented from regular smoking would mean 60,000 to 100,000 fewer deaths each year, an estimate derived from white middle class populations.[22] In his largest study of disadvantaged minority youth, post-intervention measures showed Life Skills curbed the increase in past-month smokers by 2%.[23] No study of a similar population gives us any clues about whether this would have been maintained, and past-week and past-day smoking were unaffected. On this basis few lives would be saved, but a longer follow up might have proved more encouraging.

Whether the curriculum leads to reduced use and fewer problems with drugs such as cocaine and heroin is even less clear. The few Life Skills studies measuring intention to use these have produced unconvincing results[24, 25] and one measuring actual use has apparently remained unpublished.[26]

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Mined, refined, assayed and set in context – nuggets of data with weighty practice implications

Nuggets features recent published and unpublished evaluations of interventions selected for their particular relevance to UK practice. An attempt is made to balance studies relating to alcohol and illegal drugs, and to prevention, community safety, and treatment. Studies are sourced mainly through Britain's national drug and alcohol information services (DrugScope and Alcohol Concern) and through our network of research contacts.

Entries are drafted by FINDINGS after consulting related papers and where possible seeking comments from the lead authors and members of FINDINGS' advisory panels or other experts. Supporting references are available on request. FINDINGS remains fully responsible for the published text.

Each entry is structured as follows:

Findings The most practice relevant findings for the UK and the main methodological characteristics of the featured evaluation(s).

In context Brief comments on the featured evaluation's methodology and findings, drawing on other related studies and the UK policy and practice context.

Practice implications The most UK-relevant practice implications of the featured evaluation(s). These suggestions are intended as a valuable input to decisions over policy and practice but they are implications rather than guidelines. *They do not constitute a sufficient basis for practice*, which should be more widely based on the available research, experience and expert opinion.

Main sources Bibliographical details of the featured evaluation(s).

Secondary sources Optionally, a selection of documents drawn on in drafting the entry. Full references on request.

Copies of cited documents may be available for a fee from Alcohol Concern (020 7928 7377) or DrugScope (020 7928 1211); please check before ordering. Reprints may also be available from the author(s). In case of difficulty contact FINDINGS (020 8888 6277).

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Links Cross reference to related items in current or past issues of FINDINGS. A *Nugget* entry referred to for example as '**1.2**' is the second entry in FINDINGS issue 1.

3.1 Careful induction prevents overdose deaths among methadone patients

Findings Substituting legally prescribed methadone for heroin saves lives but entails overdose risks for patients who continue illegal drug use, especially early in treatment.

By guaranteeing confidentiality to the doctors involved, study ❶ was able to audit shortcomings in the preceding two weeks which may have contributed to the 32 methadone-related deaths in Glasgow in 1995. Failure to examine for and/or to respond to continued illegal use of drugs was apparent in most of the 19 cases where the deceased was being prescribed methadone. Poor supervision of prescribing may have caused three deaths where the dose was excessive and six where the patient did not take the methadone as directed by the doctor.

LINKS *Nuggets* **2.1** **2.3**

The role of continuing illegal drug use was confirmed in study ❷ of the 238 deaths during methadone maintenance in New South Wales between 1990 and 1995. 105 deaths were recorded as "drug-related" – presumably mainly overdoses. All but seven involved drugs in combination with methadone (generally depressants such as benzodiazepines, opiates and alcohol) and 4 in 10 occurred in the first week of treatment. Excessive starting doses of methadone and over-rapid increases might have contributed to many of the deaths.

In context The danger of using 'on top' of methadone has been confirmed by pathology-based assessments implicating other drugs in three-quarters of methadone-related deaths in Strathclyde. Alcohol plays a prominent role. However, in both Australia and Glasgow the potential for methadone alone to cause deaths may have been obscured because the drug is usually taken under supervision in the clinic. In England and Wales, where supervised consumption is less dominant, in the first half of 1998 a sample of coroners reported that 45 methadone patients had died from methadone with other drugs, but another 24 from methadone alone.

Study ❷ confirms the elevated risk of overdose fatality in the first weeks of methadone treatment. Even low doses could accumulate dangerously in the first few days because new users take longer to clear the drug from their bodies. Dangers are exacerbated because tolerance to methadone's depressive effect on breathing (main cause of death) develops slower than tolerance to its psychoactive effects.

In both studies some of the deaths may have been suicide – among drug users, hard to distinguish from accidental overdose. Nine out of 13 methadone patients in Scotland who had survived a methadone overdose said it was deliberate. Many drug treatment clients in Britain contemplate suicide and an increasing proportion use their prescribed methadone to carry out the act.

While the focus here is on deaths among methadone patients, study ❶ also highlighted the danger of methadone diverted on to the illicit market, a factor in 13 of the 32 deaths and in most methadone overdose fatalities in England and Wales.

Practice implications For UK guidelines ◤ *Secondary sources*. The balance between preventing methadone overdose and leakage on to the illicit market, while not impeding access to treatment, is particularly delicate in the first weeks when failure to adjust doses or to spot supplementary drug use can lead to deaths. These will be minimised if prescribers carefully examine for drug use by physical means (urinalysis, recent track marks) and respond to admissions of 'topping up' in ways which encourage openness. Alcohol is at least as dangerous as other depressant drugs. Caution in prescribing initially low doses should be balanced by frequent monitoring (within hours and then daily for the first few days) of the patient's need for increased or repeated doses in order to avoid resort to illicit supplies.

Main sources ❶ Scott R.T.A., *et al*. "A confidential enquiry into methadone-related deaths." *Addiction*: 1999, 94(12), p. 1789–1794 ❷ Zador D. *et al*. "Deaths in methadone maintenance treatment in New South Wales, Australia 1990–1995." *Addiction*: 2000, 95(1), p. 77–84. Copies: for both apply DrugScope.

Secondary sources Department of Health *etc. Drug misuse and dependence – guidelines on clinical management*. HMSO, 1999. Copies: phone HMSO on 0171 873 9090, or download from http://www.doh.gov.uk/drugdep.htm.

Contacts ❶ Robert Scott, Glasgow Drug Problem Service, phone 0141 946 7120, fax 0141 945 2717 ❷ Deborah Zador, Drug and Alcohol Department, Concord Repatriation General Hospital, Hospital Road, Concord NSW 2139, Australia.

3.2 Methadone's failures respond to heroin

Findings A large Swiss trial found that heroin addicts who failed on methadone responded well to treatment based on injectable heroin.

At 17 outpatient centres an average of just under 500mg of heroin a day was injected three times a day under clinical supervision. To qualify, patients had to be aged 20 or more with marked social and health damage from at least two years of injectable heroin addiction despite repeated treatments. Detailed outcomes are reported for the 237 who *remained* in treatment for 18 months from 385 who started before April 1995. Preliminary data are also available from a 1997 follow-up of *all* patients admitted at least 13 months earlier.

Findings can be roughly benchmarked against Swiss methadone programmes and British programmes sampled by NTORS. On heroin 76% were retained for at least a year, a fifth more than on methadone, and most leavers went on to more progressive treatments. In the six months before treatment about 80% had used illegal heroin virtually every day. By 1997 this had dropped to between 3% and probably well under 16%, compared to 40% two years after starting in NTORS. On entering treatment 31% had gained income from crime in the previous six months. By 1997 this had fallen to between 5% and probably well under 18%, compared to at least 21% two years after treatment entry in NTORS.

Improvements were also seen in cocaine and benzodiazepine use, in employment, housing and financial situations, in injection-related damage, and in psychological health. Though at first several patients had to be resuscitated, none fatally overdosed on prescribed heroin. A death rate of 1% per treatment year compares well with other treatments, especially since many deaths were probably due to pre-existing diseases. Known new infections were extremely rare. Costs per treatment day were estimated at £20 and benefits (mainly from savings to the criminal justice system) at £40.

In context For a comprehensive critique ◤ *Secondary sources*. Switzerland is an affluent country with a well-resourced treatment system. Even its most severely affected heroin patients compare well with those presenting for treatment in Britain. In particular, addicts in Britain are far more criminally active, creating greater scope for cost savings from reducing crime. The costs of the Swiss treatment exceeded what we know of similarly resourced methadone maintenance in Britain, but probably by a factor of less than two.

Absence of a control group given oral methadone makes it unclear to what extent the improvements were due to heroin or to the intensive psychosocial therapy, and the main findings exclude treatment leavers, 40% of whom were not re-interviewed for the 1997 follow-up. However, therapy was not as intensive as planned, most leavers went on to further treatment, and improvements in crime and drug use would have remained impressive even had all the patients been re-interviewed. Whether they would have been more impressive than after a well-resourced further attempt on oral methadone is uncertain: half the patients had tried this only once or not at all.

Practice implications Oral methadone remains the frontline response to heroin addiction. Developing methadone programmes will be the priority in many areas where waiting lists make it hard to justify the more expensive heroin option. However, with respect to crime, illicit opiate use and psychological wellbeing, many severely addicted patients for whom oral methadone has failed, and those seeking treatment but unwilling to give up heroin, do better on heroin than methadone. Heroin prescribing has extra 'pulling power' in terms of attraction into treatment and retention; its downside is an entrenchment of heroin injecting in some who might otherwise have stopped. The Swiss studies show that a heroin regime featuring on-site consumption and a high level of services can be safely delivered from methadone clinics, and that patients can manage on a stable if high dose without resort to the 'topping up' typical on methadone.

Main sources Uchtenhagen A., *et al*. *Prescription of narcotics for heroin addicts. Main results of the Swiss National Cohort Study*. Karger, 1999. Copies through bookshops or e-mail karger@karger.ch.

Secondary sources Ali R., *et al. Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts.* WHO, 1999. Copies: apply DrugScope.

Contacts Ambros Uchtenhagen, Institut für Suchtforschung, Zurich, fax 00 41 1 273 40 64, e-mail uchtenha@isf.unizh.ch.

LINKS *Nuggets* **1.5**
NTORS, issue 2, p. 16

3.3 Injuries reduced even when interventions do not stop problem drinkers drinking

Findings After an unusually thorough attempt to garner all the available evidence, researchers suggest that treatment and other interventions with problem drinkers can reduce injuries and deaths due to accidents even when this is not the aim of the intervention and even when drinking appears unaffected.

The authors searched general, alcohol, and accident-related databases, contacted relevant institutions, and asked authors for further published or unpublished work – one way to overcome bias towards publishing studies with positive outcomes. Only studies in which interventions were compared with control or comparison conditions to which subjects had been randomly allocated – the most satisfactory way to establish efficacy – were included in the review. If reports did not mention relevant outcomes, authors were contacted for any unpublished data on injuries.

The search uncovered 19 randomised controlled trials of interventions with alcoholics or other problem drinkers which reported injury-related outcomes. Seven of these compared interventions to a control condition as opposed to another intervention; in nearly all the comparisons, interventions reduced injuries, in some cases substantially. This was true whether the recorded outcomes were fatal injuries, non-fatal injuries, violence, or motor vehicle crashes and injuries. Several studies reported that reduced injuries or violence were not associated with reduced drinking.

The authors' conclusion that "interventions to reduce problem drinking could have an important effect on the incidence of injuries and deaths" is expressed tentatively because of the poor quality of many studies and small sample sizes.

LINKS *Nuggets* **3.4 3.10**

In context UK figures show that 1 in 7 road accident deaths result from drink-drive incidents. Studies usually implicate alcohol in a large minority of fatal and non-fatal accidents and sometimes in the majority. As campaigns and laws here and overseas have reduced the overall level of drink driving, attention has turned to the residual 'hard core' of undeterred heavy drinkers who repeatedly offend and who may account for a high proportion of drink-drive fatalities. Many of these are problem drinkers, and many are alcohol dependent. Approaches similar in principle to those used to treat problem drinkers have proved a more promising approach to drink-drivers than educational approaches. However, treatment of problem drinkers can only have a limited impact on the overall level of alcohol-related injuries: many occur during an episode of intoxication which is not part of pattern of problem drinking susceptible to treatment-type interventions.

In the reviewed studies the most common indicator of whether drinking had been reduced was the percentage of subjects totally abstinent; changes in the amount drunk or in patterns of use might be more relevant to whether injuries occur.

Practice implications Impacts on injuries (to self and others) should be among the outcomes evaluated even when problem drinking is the focus of the intervention. Reduction of harm from injuries may be one highly desirable outcome with clients who do not achieve abstinence. If further research substantiates the trends documented in this study, cost-benefit analyses of alcohol treatment will need to take into account potentially substantial savings in health costs (particularly emergency attendances and admissions to hospital) and other costs due to injuries.

Main sources Dinh-Zarr T., *et al*. "Preventing injuries through interventions for problem drinking: a systematic review of randomized controlled trials." *Alcohol and Alcoholism*: 1999, 34(4), p. 609–621. Copies: apply Alcohol Concern.

Contacts Carolyn Diguiseppi, Institute of Child Health, University College London Medical School, 30 Guilford Street, London WC1N 1EH.

Baffled by the jargon? Check the Glossary ◤ back cover

3.4 Not just for the patients: community health and safety benefit from alcohol treatment

Findings Whilst beneficial for the individuals concerned, treating heavy drinkers has not been seen as a way to reduce the overall level of alcohol-related problems in society. Attention has instead focused on initiatives to prevent heavy drinking or reduce drinking levels across the board. However, a new review has convincingly argued that treatment's impact on some of these problems is perhaps as great as conventional prevention policies.

The researchers first recap evidence showing that interventions targeting high-risk drinkers (treatment, membership of Alcoholics Anonymous, drink-driving programmes and brief interventions in primary care) do reduce their drinking and related problems. Then they assess the evidence that at a community level (city, state or country) these impacts cumulate into worthwhile reductions in alcohol-related problems.

Evidence (mostly from North America) was strongest for cirrhosis of the liver. At varying time lags, greater participation in conventional treatment and in Alcoholics Anonymous (AA) were associated with fewer cirrhosis cases and fatalities. There was also some evidence of an impact on accidents and drink-driving. Effects may have been substantial: mathematical models suggest that increased participation in treatment/AA alone could have accounted for the reductions in cirrhosis deaths in the USA and in Ontario in the 1970s and '80s. Importantly, these benefits could not be explained by changes in the availability and overall consumption of alcohol.

The authors admit that showing a link between treatment/AA and community-level alcohol problems does not prove one caused the other. A plausible alternative explanation is that both trends result from changes in policy and public opinion relating to alcohol. However, on balance they argue that treatment interventions should be seen as a viable public health strategy which can achieve 'prevention' outcomes similar to those expected from population-level prevention approaches.

LINKS *Nuggets* **3.3**

In context The idea that engaging relatively few severely problematic substance users in treatment can have worthwhile impacts on public health and welfare is common currency in the drugs field, where preventing infectious diseases spreading to the general population and protecting them from crime are major justifications for investing in addiction treatment. The current review extends this perspective to alcohol treatment. Along with other studies (◤ *Nuggets* 3.3) it argues for treatment to be seen as creating public health and community safety benefits for society at large. Evidence is strongest for cirrhosis perhaps because it is most amenable to alcohol treatment. Caused by heavy, prolonged drinking, it can nevertheless be stabilised and its precursors reversed by abstinence.

Practice implications The issue of the journal which published this study also published five experts commentaries which generally endorsed its conclusions and explored the implications. If confirmed, these would justify more aggressive marketing and outreach initiatives to bring currently unmotivated risky drinkers into treatment, and treatment regimes which target the social and public health consequences of risky drinking (◤ *Secondary sources*). Lasting abstinence might no longer be the yardstick of success, as repeated treatment episodes can still reap social and public health benefits. Health services may be encouraged to fund treatment expansion by the prospect of savings to their own budgets due to reduced alcohol-related disease and injury.

Rather than one being an alternative to the other, treatment and conventional prevention are best seen as complementary ways to reduce the overall level of alcohol-related problems: they affect different types of drinkers and drinking patterns, so are likely to affect different types of problems. Even when the same problem (eg, car accidents) is affected, their impacts are likely to be additive.

Main sources Smart R.G., *et al*. "The impact of programs for high-risk drinkers on population levels of alcohol problems." *Addiction*: 2000, 95(1), p. 37–52. Copies: apply Alcohol Concern.

Secondary sources Stockwell T. "A bridge to cross the treatment-prevention divide?" *Addiction*: 2000, 95(1), p. 57–58. Copies: apply Alcohol Concern.

Contacts Reginald Smart, Centre for Addiction and Mental Health, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M55 2S1.

3.5 'Wet shelter' becomes home for street drinkers

Findings After an uncertain start, an experimental project in London's East End safely housed long-term rough sleepers unwilling to stop drinking, connecting them to medical and other services whilst allowing drinking on the premises.

Providence Row opened in 1995 as a direct access 'wet' hostel in an area with a highly visible street drinking population. Its evaluation is based on staff and resident interviews, on-site observations, and project records. Usually full, from the start the hostel attracted and retained clients more often associated with very short stays. Close working with local benefits agencies helped stabilise residents' financial situations while basic care such as meals and dispensing medication improved health. Nuisance from street drinking and begging were reduced. However, in its first phase the project never became a safe environment which residents saw as home, and did not provide services to further improve health and tackle drinking. This was partly due to unsuitable premises and understaffing, but partly to management style. Some other agencies disapproved of the project's approach and staff retreated into a 'siege mentality' which further impeded liaison with services important to the clients' welfare. Tension, arguments and occasional violence led residents to leave and deterred applicants. A non-interventionist stance on drinking spilled over into facilitating it, into a dangerously laissez faire attitude to issues such as taking medication, and into a failure to provide opportunities for residents to consider routes out of dependence on alcohol.

Improvements rapidly followed a move to more suitable premises. Residents had greater privacy, the layout encouraged natural friendship groups, and a high quality, non-institutional design fostered a sense of ownership. 'Drop in' stayers (responsible for much of the previous disruption) were banned. Rather than excusing residents as unable to control themselves, the disciplinary code was enforced. Key working – the axis around which more proactive care might have occurred – was properly instituted. Relationships were forged with external alcohol agencies. A service agreement with a local GP practice allowed residents to register on a permanent basis, markedly improving health care. Compared to its previous phase, twice as many residents (half the total) stayed for at least three months and more moved on to treatment and alternative housing. Nevertheless, 'bed blocking' became a problem. With no structured in-house alternatives to drinking and a remaining reluctance to initiate discussions about rehabilitation, opportunities for tackling drinking and encouraging a more ordered lifestyle were still missed. Few female clients were attracted into a male environment.

In context Visible homelessness and street drinking (especially in London) are government priorities which overlap in Providence Row's client group. Despite common and acute health and substance abuse problems, access to primary care is blocked by GPs' reluctance to register homeless patients, whose mobility impedes continuity of care. The consequence is an increased load on emergency services due to untreated complaints. Common requirements that hostel applicants are sober on entry, that residents do not drink on the premises, and that they address their alcohol problems, act as barriers to housing and retaining these clients.

Practice implications High-support wet shelters can operate safely, enable enhanced care of residents, and reduce street drinking and related nuisance. Achieving a balance between accepting risky drinking and poor behaviour and trying to address them requires clear guidelines endorsed by staff and clients. Taking long-term responsibility for a medically compromised group who continue to drink heavily demands a high level of medical care and staff training. Successful projects could quickly find themselves unable to accept new referrals. Move-on accommodation is often predicated on residents' having controlled their drinking. For this and for health reasons, opportunities must be provided to tackle drinking without making this a requirement. At Providence Row, such issues are being addressed by volunteer support and long-term counselling.

Main sources May J. *The accommodation and care of homeless street drinkers: an evaluation of Providence Row's wet shelter programme*. Providence Row, September 1999. Copies: apply Providence Row, phone 020 7375 0020, fax 020 7377 6432.

Contacts ❶ For the project ◤ *Main sources* ❷ For the research: Dr Jon May, Queen Mary and Westfield College, London, phone 020 7882 5427, e-mail J.May@qmw.ac.uk.

3.6 Sympathetic ear helps clients overcome dependence on amphetamine

Findings A British study has highlighted the role of counselling in treating dependence on amphetamine, the use and transition to non-use of which seem intimately bound up with social relationships.

58 new amphetamine using clients were identified by 16 drug agencies. They were daily or very frequent users averaging nearly 4gm a day and 59% injected. Researchers interviewed them within about a month of starting treatment and then monthly for the next two months, when 49 were left in the sample. Report 1 established that treatment was among the factors associated with giving up illicit amphetamine; reports 2 and 3 assessed its impact by comparing 43 clients against individually matched controls not in treatment.

Two months after treatment entry 43% of clients had stopped using illicit amphetamines, rare among controls. Clients had also cut average consumption by about twice as much, and used twice a week compared to 4–5 days a week. Over a third of injecting clients but only 4% of controls had stopped injecting. After treatment 17% of clients committed non-drug crimes in the previous month compared to 67% in the three months before treatment; figures for controls were 50% and 93%. Adjusting to life without amphetamine probably accounts for failure to report improved physical or psychological health in the first months of treatment, when thoughts of suicide were over twice as common (34% v.16%) among treated subjects as controls.

Clients who stopped using amphetamine were more likely see their drug worker as helpful (55%) than those who continued using (19%), whose main source of support was more likely to be family and friends (41%). For many what the worker provided was time to talk and an understanding and sympathetic ear, seen as key supports in achieving abstinence.

LINKS *Nuggets* **2.2 3.7**

In context While policy and research have focused on amphetamine prescribing, in this and in other studies a sympathetic listener seemed more highly valued by most clients. Such support may be more reliably obtained from a professional than from friendship and family networks disrupted first by the client's dependence on amphetamine and then by mood changes whilst adjusting to life without the drug. For the same reasons clients and controls may have valued and benefited from monthly interviews with the same researcher.

Many clients were prompted into treatment by severe disruption to relationships and psychological health. Such 'bottoming out' may be an artifact of the barriers to accessing treatment for stimulant abuse, which only the more desperate would surmount. Given this, some degree of natural recovery is to be expected. However, because controls were not (as far as we know) also trying to stop using amphetamines, the study cannot assess how many clients might have overcome their drug problems, even without treatment. In one UK study a third of attempts to self-detoxify from amphetamine were successful for at least three months. Researchers could not have been 'blind' to whether the interviewee was a treatment or control subject, and clients may have wanted to present a good impression of their progress in treatment. However, the results do not suggest systematic bias towards a rosier picture of the treatment group.

Practice implications Social relationships are often central both to starting and to stopping amphetamine use. The initial treatment contact is a crucial time: users have overcome the stigma of approaching a drug service for help yet are unsure what to expect and easily deterred. After stopping amphetamine, accessible, regular support is important in working through a period when a prop to self-esteem and everyday living has been removed and former users are at a low ebb, straining personal relationships. Continued recovery will be aided by the boost to self-esteem derived from managing without amphetamines. Substitute prescribing should be considered for more dependent users, who are also more likely to inject.

Main sources 1 Klee H., *et al*. "Amphetamine users in treatment: factors associated with sustained abstinence from street drugs." *Addiction Research*: 1999, 7(3), p. 239–265 2 Department of Health. *Amphetamine use and treatment*. 1998. Copies: for both apply DrugScope 3 Klee H., *et al*. *Amphetamine use and treatment. Part 2: treatment and its outcomes.* Centre for Social Research on Health and Substance Abuse, Manchester Metropolitan University, 1999. Copies: Manchester Metropolitan University, fax 0161 247 6884.

Contacts Hilary Klee, Manchester Metropolitan University, phone 0161 247 2585, fax 0161 247 6394, e-mail H.Klee@mmu.ac.uk.

3.7 Client-receptive treatment more important than treatment-receptive clients

Findings Interviews with drug abuse counselling clients confirmed that engaging with treatment is associated with good outcomes and that both depend on how well the counsellor relates to the client.

All but two of the 419 clients entering outpatient drug-free treatment in Los Angeles in the third quarter of 1994 completed intake interviews. 356 were re-interviewed eight months later, when for most treatment had recently ended. 302 had only used outpatient drug-free treatment and were included in the analysis. Most took stimulants rather than opiates. Previous studies had found that 'treatment engagement' (retention plus attendance at counselling sessions) led to better abstinence outcomes. The current study investigated which features of the client and the service encouraged engagement.

Report 1 found that how the client perceived the service (as recalled at follow-up) was far more strongly linked to engagement than pre-treatment client characteristics such as criminal history and motivation. Significant factors for women included how much they thought their counsellor cared about them, for men how helpful the counsellor had been. Report 2 found that empathy (feeling the counsellor understands you) was also related to engagement, and to abstinence from illicit drugs in the six months before follow-up. Empathy was greater if counsellor and client were of the same gender and ethnicity, but engagement was no better and outcomes only patchily and moderately. Except for Latinos, assigning clients a counsellor they saw as highly empathic would lead to better outcomes than assigning on the basis of race and gender.

In context Results were consistent with other studies which found that client characteristics do not affect engagement directly but by influencing the therapeutic relationship. Dimensions of the client-counsellor relationship such as 'rapport' seem to act as the melting pot where client and service meet to influence retention and outcomes. However, this relationship accounts for only a small part of differences in engagement and outcomes; even clients with a poor relationship with their therapist may do well and vice versa.

The study is vulnerable to the 'halo effect': clients who did well may recall treatment in a better light. However, compensating for this did not affect the results and other studies have related later improvements to earlier feelings of rapport. Just 30% of the clients were of European extraction and two-thirds were women, demanding caution in extrapolating certain of the findings to the white, male, opiate addicts seen at British services. However, the impact of the client-counsellor relationship is likely to cross borders and substances. In report 1 the client's perception of how far the counsellor understood them did not predict retention once other factors had been taken into account. Only a similar analysis could have confirmed whether empathy would have suffered the same fate in report 2.

Practice implications Important as treatment methods are, the therapist's personal style should not be overlooked, particularly when (as in non-prescribing therapies) the client-therapist relationship is the main therapeutic tool. There is no rationale in these findings for giving up on 'unpromising' or 'unmotivated' clients. Instead the onus is on therapists to quickly establish a relationship within which the client has reason to feel they are being listened to, understood, and being given helpful, positive responses. Given this, more will stay longer and attend more often, improving outcomes.

There are obvious implications for the training and supervision of therapists, and perhaps most of all for recruitment procedures, which should attempt to assess qualities such as empathy. Services cannot assume that matching for gender or race will create a bond between client and counsellor. However, a varied staff team may still be important in *attracting* clients and matching may help with certain sub-groups; in the current study women, Latinos and older clients did respond slightly better to same-sex counsellors.

Main sources 1 Fiorentine R., *et al*. "Client engagement in drug treatment." *Journal of Substance Abuse Treatment*: 1999, 17(3), p. 199–206 2 Fiorentine R., *et al*. "Drug treatment effectiveness and client-counselor empathy: exploring the effects of gender and ethnic congruency." *Journal of Drug Issues*: 1999, 29(1), p. 59–74. Copies: for both apply DrugScope.

Contacts Robert Fiorentine, UCLA Drug Abuse Research Center, Los Angeles, USA, fax 00 1 310 473 7885, e-mail fiore@ucla.edu.

LINKS *Nuggets* **2.2 3.6 3.7**

3.8 Acupuncture yet to convince

Findings Three trials which randomised patients to acupuncture at sites on the ear recommended for addiction or at nearby 'sham' sites have not demonstrated an advantage for the recommended sites.

Modelling itself on a landmark study which did record benefits from recommended sites, study ❶ randomised 72 alcohol dependent patients from a Swedish outpatient clinic to recommended or sham acupuncture additional to usual treatment. Though men given the recommended treatment tended to stay longer, interviews conducted up to six months after treatment started revealed that the only significant impact was temporary reduction of anxiety among women. Drinking and craving for drink were unaffected.

The next two studies involved US cocaine dependants. Study ❷'s methodology was similar to that of study ❶. 36 men received acupuncture as well as usual inpatient treatment and outpatient aftercare. Using recommended sites did not reduce cocaine use or craving. However, both sets of patients were retained in treatment longer than previous patients not given acupuncture.

The possibility that 'sham' sites are nevertheless effective was tested at a US therapeutic community in study ❸. It was led by Dr Bullock, whose work inspired studies ❶ and ❷. 236 volunteers were randomised to usual therapy or additionally to eight weeks' acupuncture. Whether the analysis included all subjects or only those who completed treatment, neither recommended nor sham acupuncture improved retention or reduced cocaine use or craving during treatment. A companion study found outcomes were not improved by higher 'doses' of acupuncture at recommended sites.

In context Using sham sites close to recommended ones is intended to ensure that patients are 'blind' to which treatment they are receiving. However, if sham sites exert a similar effect (and there is evidence that they do), this would account for the typical finding of no advantage for recommended sites.

Some studies have found that both sham and real sites improve outcomes over conventional treatments. Conceivably the value patients attach to acupuncture encourages retention, giving treatment time to work, an effect hinted at in studies ❶ and ❷. Improved retention was one of the clearest findings in a report on complementary therapies at a British alcohol service ◤ *Secondary sources* ❶.

An expert panel convened by the US government saw the evidence for acupuncture in addiction as less convincing than in other sectors but promising enough to support its use within a comprehensive programme ◤ *Secondary sources* ❷.

In study ❶ scoring drop-outs as treatment failures would if anything have biased the results in favour of 'real' acupuncture, adding weight to the negative findings. High drop-out rates in studies ❷ and ❸ would have mitigated against finding benefits from acupuncture.

Practice implications Typically offered by drug and alcohol services (if at all) as an 'optional extra', acupuncture will usually only be tried and persisted in by clients who value it. For this *self-selected* group retention and outcomes may be improved just as they may be by other valued services (childcare, transportation, etc). However, evidence from trials which *randomised* clients to acupuncture does not justify its provision as a mandatory or central feature of a therapeutic programme. Complementary therapies may particularly help attract and retain clients from cultures and subcultures in which these approaches are accepted and valued.

Main sources ❶ Sapir-Weise R. "Acupuncture in alcoholism treatment: a randomized out-patient study." *Alcohol and Alcoholism*: 1999, 34(4), p. 629–635. Copies: apply Alcohol Concern ❷ Otto K.C., *et al.* "Auricular acupuncture as an adjunctive treatment for cocaine addiction." *American Journal on Addictions*: 1998, 7(2), p. 164–170. Copies: apply DrugScope ❸ Bullock M.L., *et al*. "Auricular acupuncture in the treatment of cocaine abuse: a study of efficacy and dosing." *J. of Substance Abuse Treatment*: 1999, 16(1), p. 31–38. Copies: apply DrugScope.

Secondary sources ❶ Burns S. *Southall Alcohol Advisory Service. Evaluation report. The complementary therapy service*. Alcohol Concern, 1999. Copies: apply Alcohol Concern ❷ *Acupuncture*. NIH Consensus Statement 107, 1997. Copies: http://odp.od.nih.gov/consensus/cons/107/107_statement.htm.

Contacts ❶ Richardt Sapir-Weise, Dept. of Alcohol and Drug Diseases, Malmoe University Hospital, S-205 02 Malmoe, Sweden ❷ Katherine Otto, 8816 Ferguson Ave., Savannah, GA 31406, USA ❸ Milton Bullock, Hennepin County Medical Center, Mail Code 865-B, 701 Park Ave. S., MN 55415, USA.

3.9 Confidence helps resist a return to drinking

Findings Severely alcoholic men lacking social supports for a drink-free lifestyle can acquire skills which will prevent a return to heavy drinking, as long as they feel confident in their ability to resist.

60 alcoholic men detoxified at a Scottish alcohol treatment unit were sequentially allocated to usual treatment over the next two weeks (the control condition) or also to one of two relapse prevention interventions. Delivered over eight one-hour sessions, these differed in method rather than content: in the skills training intervention clients practised skills and strategies to handle high-risk situations; in the discussion intervention they talked about them. Outcomes were assessed six and twelve months after treatment. Report ❶ reveals that lapses (any drinking) and relapses (heavy drinking) were significantly delayed by skills training, for relapses typically by five months. Though 12 months later treatment effects had faded or were obscured by drop-out, at six months far more of the skills group (40% v. 5%) had sustained abstinence and 25%–35% fewer had drunk heavily or experienced symptoms of dependence.

LINKS Nuggets **3.7** • *Project MATCH: unseen colossus,* issue 1, p. 15

Report ❷ probed for underlying variables which may have led to these outcomes. The client's confidence in their ability to resist the urge to drink heavily (as expressed immediately after treatment) was the variable most closely related to sustained improvement. Termed 'self-efficacy', it was also more clinically relevant than other variables because it can be enhanced by treatment. There was evidence that the skills training intervention had significantly enhanced self-efficacy and that this at least partly accounted for better outcomes.

In context Small samples could have prevented further differences in outcomes emerging but do not invalidate such as were found. The individual who developed the skills intervention also interviewed the subjects. However, his assessments were randomly checked by an independent 'blind' interviewer. Inpatients and outpatients were approached for the study but there is no report of the mix in each group or whether this affected the results. Had patients with a history suggestive of damaged brain function not been excluded, factors such as self-efficacy might have proved less significant. We do not know if the treatments were delivered as intended. Research appointment reminders led several subjects to curtail drinking, a serendipitous finding which accords with research indicating that post-treatment checks on progress exert a restraining effect.

In Project MATCH, a large US alcohol treatment trial, self-efficacy at treatment entry was one of the few variables to predict later drinking. The featured study suggested that raising concern over drinking without enhancing confidence in tackling it could be counter-productive. Consistent with this, MATCH found that clients with low self-efficacy did less well during motivational enhancement therapy. Research generally has found skills-based relapse prevention better than no intervention, usually better than discussion groups, and about as effective as other psychotherapies ◤ *Secondary sources*.

Practice implications The study adds to evidence that treatment services do not have to accept that unpromising clients will do badly, but can alter motivation and (in this case) self-efficacy in ways which promote recovery. Confidence in one's ability to resist a return to heavy drinking can be bolstered by active learning of strategies and skills to handle high-risk situations. Successful 'dummy runs' in less challenging situations seem particularly likely to boost confidence and create a virtuous circle. However, an environment which (as in this study) offers few satisfying alternatives to drinking and abundant temptations will often test such skills to breaking point, placing an onus on services to encourage countervailing social networks such as Alcoholics Anonymous. Skills-based relapse prevention is not cheap in training (20 hours in the featured study) or delivery time, but if it minimises relapse it could save sufficient police and health resources to justify the investment.

Main sources ❶ Allsop S., *et al*. "A trial of relapse prevention with severely dependent male problem drinkers." *Addiction*: 1997, 92(1), p. 61–74 ❷ Allsop S., *et al*. "The process of relapse in severely dependent male problem drinkers." *Addiction*: 2000, 95(1), p. 95–106. Copies: for both apply Alcohol Concern.

Secondary sources Carroll K.M. "Relapse prevention as a psychosocial treatment: a review of controlled clinical trials." *Experimental and Clinical Psychopharmacology*: 1996, 4(1), p. 46–54.

3.10 Brief intervention leaves teenage drinkers less likely to revisit accident and emergency

Findings A brief intervention aimed at teenagers attending accident and emergency units after an alcohol-related incident cut the number of such incidents in the following six months.

Staff and researchers in a busy urban US hospital emergency room identified 184 18–19-year-olds who had drunk alcohol prior to the event that led to their attendance. 141 were there long enough to be invited into the study. 94 agreed and were randomly assigned to receive a handout on drink-driving plus a list of local alcohol agencies (the control condition) or a 35–40 minute motivational intervention intended to reduce harmful/risky drinking. Roughly 90% completed outcome interviews three and six months later.

Before conducting the interventions research staff took baseline measures, including an assessment of the patient's 'involvement' with alcohol which was fed back during the motivational session. This was also personalised in relation to the event which precipitated attendance. In the year before admission patients on average admitted to drinking nine units of alcohol twice a week. In the following six months both groups reduced their drinking. However, clients offered the motivational intervention evidenced greater reductions in drink-related problems: 23% fewer admitted drink-driving, far fewer were convicted of traffic violations, one in five suffered an alcohol-related injury compared to half the controls, and there were fewer alcohol-related conflicts with friends, family or authority figures.

In context The US 'legal drinking age' is 21 rather than 18, perhaps why nearly half the patients attended solely because they were intoxicated, raising a query over transferability of the results to the UK. The control handout focused on drink driving so may have seemed irrelevant to the three-quarters of the sample not attending after a motor accident, giving the motivational intervention a head start.

At up to 40 minutes, the intervention tested in the study was already at the upper end of 'brief'. However, far more was involved than just the session itself, adding to the cost. Motivational patients were encouraged to commit themselves to drinking/harm reduction goals; the knowledge that within a few months their commitment would be checked may have stiffened their resolve. Perhaps more so than controls, they may have reacted to intervention and research assessment as if they were one; they were conducted sequentially by the same person, and one included feedback from the other. Therapists were specially recruited, extensively trained, and supervised weekly.

This is not the first study to have found that a brief intervention in hospital reduced drink-related problems but not drinking as such. However, the featured study's drinking measure conflated indices of amount, frequency and intoxication, obscuring potential impacts on patterns of drinking most likely to lead to accidents.

LINKS *Nuggets* **2.7 2.8 3.3** • *How brief can you get?* issue 2, p. 23

Practice implications Youngsters not yet fixed in their drinking habits and (generally) not alcohol dependent can be expected to react well to an intervention timed to coincide with a serious reminder of the immediate risks of injudicious drinking. However, the situation which creates this opportunity also entails logistical problems (short stays and having to wait for patients to sober up) apparent in the high proportion of patients in the study who left before they could be approached.

With no cost data and no indication of how *many* injuries may have been prevented, even a guess at the cost-benefit balance cannot be attempted, but savings would have to be substantial to offset the costs of deploying specialist staff. Using regular staff is cheaper, but it is difficult to persuade pressured nurses to implement interventions seen as peripheral to their core task. A short information-only intervention, especially if it could be tailored to the incident which led to admission, might prove as or more cost-effective because it can more readily be learnt and delivered by regular staff.

Main sources Monti P.M., *et al*. "Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department." *Journal of Consulting and Clinical Psychology*: 1999, 67(6). Copies: apply Alcohol Concern.

Contacts Peter Monti, Center for Alcohol and Addiction Studies, Brown University, USA, fax 00 1 401 444 1850, e-mail Peter_Monti@brown.edu

3.11 Clash of philosophies impedes work with young drug using offenders

Findings A report on two innovative British projects provides valuable clues to the obstacles to be overcome as the youth justice system prepares to handle more teenage drug users.

Projects in Sandwell and Derby sited a drug specialist in a youth justice team to work with drug using offenders under 18 referred by the team or by other criminal justice sources. Data from records was supplemented by interviews with staff and management and with 30 of the 113 referrals. Half the referrals had problems with cannabis and/or alcohol, 1 in 5 heroin, and 1 in 7 amphetamine, though for just 7% had drug offences precipitated the current contact. Typically aged 15–16, their drugs experience was extensive and stretched backed over five years of a disrupted and delinquent childhood: two-thirds had been excluded from school and a third of interviewees had been 'in care'. Some said they offended to buy drugs, many did not.

Access to the specialist was gatekeeped by youth justice staff who lacked relevant assessment skills and (with few suitable services to refer on to) had tended to ignore the subject of drugs. Their priority was to avoid children being 'sucked into the system', at odds with longer term drugs work. The drug specialists were drawn into working with clients' families and other issues also being addressed by generic workers, creating tension over boundaries. Accustomed to guaranteeing confidentiality, they had to come to terms with being in a team where another professional held statutory responsibility for their client. These obstacles meant that at first the workers received few referrals. Problems were partially overcome by informal contacts, training (especially by the drug worker), referral guidelines, and agreements on sharing information. Despite the difficulties, the teams valued and to some extent absorbed the expertise of the specialists, and clients were generally positive. The drug workers developed an individualised, holistic approach, finding 'packages' of care inappropriate for this age group.

LINKS *Nuggets* **2.10 2.11 2.14 3.12**

In context The study's main shortcoming is that clients for interview were selected by the drug workers and many refused or were no longer in contact, leaving an unrepresentative sample. The three-quarters not interviewed might have contradicted impressions given by those who were. Findings are vulnerable to the idiosyncrasies of the teams studied, though their experiences are convincingly related to general modes of working in drug agency and youth justice settings.

Practice implications For a comprehensive account ◤ *Secondary sources*. Many planned or current means of encouraging drug using offenders into treatment are less applicable to young people. However, short-term action plan orders by the courts and final warnings for young offenders should soon feed young drug users into the new youth offending teams. Home Office approved guidelines suggest these appoint drug workers to whom all drug-related cases are referred following assessments which should always cover drugs. The more interventionist style of the new structures should reduce the conflicts seen in Sandwell and Derby, but these may still occur until drugs work is absorbed into mainstream practice, a development justified by the high proportion of young offenders deeply involved with drugs. Meantime guidelines will help but will not substitute for shared understandings of how to work with drug use and young offenders; training and informal contacts in shared premises develop such understandings. Working with young problem drug users means small caseloads, in the study about five referrals a month. Before youngsters reach this point, schools, social services and criminal justice agencies will have had repeated warnings of the trouble to come. The new final warnings may enforce earlier intervention.

To avoid bottlenecks, more services suitable for young drug users will be needed which can work with their family and professional networks, and with drug problems as much or more to do with cannabis, alcohol and solvents as heroin.

Main sources Newburn T., *et al*. *Risks and responses: drug prevention and youth justice*. Drugs Prevention Advisory Service (DPAS), 1999. Copies: DPAS, phone 020 7217 8631 or download from http://www.homeoffice.gov.uk/dpas.

Secondary sources *Drugs and young offenders: guidance for drug action teams and youth offending teams*. DPAS and SCODA, 1999. Copies: ◤ *Main sources*.

Contacts Tim Newburn, Goldsmiths College, London, phone 020 7919 7760, e-mail t.newburn@gold.ac.uk.

3.12 Treatment with drug testing promises to cut national burden of drug-related crime

Findings An interim evaluation of pilot drug treatment and testing order (DTTO) schemes helped persuade government to implement the orders nationwide from October 2000. The key finding was a dramatic reduction in offending.

The orders are community sentences combining treatment for drug-taking offenders with regular drug testing and review by the courts to assess whether their progress requires a change in the order. Orders can be applied to offenders aged 16 or over whose drug misuse requires and is susceptible to treatment. The intention is to tackle high-rate property offending to finance drug use. To make an impact the orders had to be convincing enough for sentencers to use them yet not so onerous that offenders would refuse them.

Researchers evaluated three pilot schemes in areas where the orders became available for offences committed after 1 October 1998; the interim report covers up to 30 June 1999. In each area DTTO teams consisting of probation officers and clinical staff assessed referred offenders and decided whether to recommend an order to the court. Out of 233 referrals, 94 recommendations were made resulting in 78 orders averaging 13 months in two areas and 17 in the third. The profile of the 78 offenders broadly matches that of criminally active drug treatment clients – young white men convicted of shoplifting who were (urine tests suggest) mainly using opiates and cocaine.

Interviews with 55 during the first month of their order revealed a pre-sentence weekly drugs bill averaging £400 and an average 107 acquisitive crimes in the month before sentence. In the four weeks before the interview these figures had fallen to £30 and 10 crimes and (although half the urine tests on the 78 offenders had been positive for opiates and 4 in 10 for cocaine) drug use had been substantially reduced. Failure to meet the conditions of the order was common. Clashing professional traditions and values were a serious obstacle to the inter-agency working integral to the schemes.

In context The teams successfully targeted high-rate offenders and their recommendations were largely accepted by the courts. Pre-sentence offending rates were comparable to those of drug users picked up by arrest referral schemes and over five times higher than criminally active drug treatment clients in general. Reductions in crime among high-rate offenders account for most of the savings due to treatment; the current study suggests that drug treatment and testing orders effectively fast track such offenders into treatment. However, the 3 in 10 not interviewed might have given a less positive impression. A throughput per scheme of 35 orders a year is far below the nearly 100 a year anticipated in the report and would not meet government expectations of 6000 nationwide in 2001–2002. Of 180 orders made up to May 2000 a third had been revoked, expected to rise to perhaps one in two.

LINKS *Nuggets* **2.10 3.11**
Pressure pays, issue 2, p. 4

Practice implications Even at current modest caseloads, DTTOs should pay for themselves by reducing health and crime-related costs imposed by drug using offenders. Performance will be improved by careful staff recruitment and training (both of which should focus on the ability to forge partnerships and enthusiasm for working with problem drug users) and by greater clarity over roles and responsibilities. Local multi-agency steering groups allow some of these issues to be addressed before teams start their work. Time absorbed in processing inappropriate referrals should be reduced by developing and publicising referral criteria.

Urine testing has proved a poor indicator of crime reduction and therapeutic progress. Before the pilots there were concerns that regular testing would provide such frequent opportunities for offenders to fail that many fundamentally doing well would have to be returned to court for resentencing. The high rate of revocations despite facilitated access to treatment, legal supervision, and the incentive of avoiding a harsher sentence, may indicate that this concern was well founded. Alternative indicators may be needed.

Main sources Turnbull P.J. *Drug treatment and testing orders – interim evaluation*. Home Office, 1999. Copies: Home Office, phone 020 7273 2084 or download from http://www.homeoffice.gov.uk/rds/publf.htm.

Contacts Paul Turnbull, Criminal Policy Research Unit, South Bank University, London, phone 020 7815 8459, fax 020 7815 5822, e-mail turnbupj@sbu.ac.uk.

3.13 Mandatory aftercare (probably) reduces recidivism after prison treatment

Findings Completion of residential aftercare proved essential to benefiting from Texas's first prison therapeutic community for drug users. The findings reinforce the importance of the throughcare element in British plans to expand treatment in prison.

New Vision is a 500-bed centre for male prisoners with a history of drug abuse. It attempts to create a therapeutic community regime based on peer influence, self-governance and group therapy. Prisoners recommended for treatment can transfer there for the last nine months of their sentence. After release on parole they are required to spend three months in less intensive residential treatment at a halfway house followed by a year of non-residential counselling.

Re-arrest records of 293 former inmates free for between 13 and 23 months were compared with a control group of 103 parolees who qualified for New Vision but who (usually for administrative reasons) were not sent there. 170 New Vision graduates completed their stay in the halfway house; 30% were re-arrested compared to 36% of those who did not complete and 42% of controls. Taking other factors into account, completers' risk of re-arrest was half that of controls. Though lower, the re-arrest risk of non-completers was not significantly different from that of controls.

Non-completers tended to report greater rapport with their former peers in New Vision, suggesting that the disjunction between its community ethos and the more traditional services offered in the halfway house had contributed to the high drop-out rate.

In context The New Vision study did not follow up therapeutic community drop-outs. Taking these into the analysis, prisoners sent to therapeutic communities across Texas are re-imprisoned at about the same rate as other similar prisoners. For a major part of the study period the former New Vision inmates were probably subject to a higher degree of legal supervision than controls. In particular, controls released straight into the community had an extra three months 'free' to commit crimes. Subtracting this period substantially cuts the apparent benefits of completing New Vision's residential phases. In other words, the findings could reflect the suppression of crime due to close supervision rather than a lasting impact of treatment.

The (mainly US) research on prison programmes is complicated by the difficulty of matching treatment and control groups without being able to allocate prisoners at random. A sophisticated study of drug treatment in US federal prisons (◤ *Secondary sources*) attempted to adjust for selection processes which could mean that people who would have done well anyway are over-represented among those who complete prison treatment. It found the reverse was the case – prisoners at *higher* risk of re-arrest and return to drug use tended to end up in the treatment sample. Taking this and other factors into account, the study calculated that just over 3% of prisoners who had completed (usually) nine months of treatment in prison were re-arrested in the six months following their release compared to 12% who had not completed. With the incentive of a year less in jail, completion rates are high: few prisoners fail or drop out of the programme. Selection processes of the kind adjusted for in this study could mean that the benefits of New Vision were underestimated.

Practice implications Evidence supporting the importance of aftercare and continuing supervision after release is stronger than for prison treatment itself. This suggests a key role for the new provisions in Britain allowing drugtakers to be released from prison on licence or under supervision notices which require them to remain abstinent from drugs and which subject them a drug testing regime. If flexibly applied (so as not to fail people who are making worthwhile progress) and if coupled with support and treatment which build on the treatment in prison, these measures could underpin a regime which optimises the chance of lasting improvements.

LINKS *Nuggets* **3.12**

Main sources Hiller M.L., *et al*. "Prison-based substance abuse treatment, residential aftercare and recidivism." *Addiction*: 1999, 94(6), p. 833–842. Copies: apply DrugScope.

Secondary sources Pelissier B.M.M., *et al*. *TRIAD Drug Treatment Evaluation Project: six-month interim report*. US Federal Bureau of Prisons, 1998. Copies: Download from Bureau web site, http://www.bop.gov.

Contacts Matthew L. Hiller, Center on Drug and Alcohol Research, University of Kentucky, USA, fax 00 1 859 257 9070, e-mail mhiller@pop.uky.edu.

3.14 Community solidarity and civil law important tools in reducing drug-related nuisance and crime

Findings Experience at drug dealing 'hotspots' in Australia and the USA has highlighted some counter-productive effects of conventional policing and the role of civil law and collective action.

Reports ❶ and ❷ drew on ethnographic fieldwork and interviews with 143 heroin users who frequented the street drug market in Sydney's Cabramatta suburb, target of a highly visible uniformed police presence and repeated crackdowns. Police action improved the quality of life locally, netted convictions, and reduced some crime. However, rather than abandoning their activities, sellers and buyers adapted in ways which increased risk and spread problems. Concealment and rapid purchase and consumption to avoid detection encouraged body cavity storage of drugs, re-use of injecting equipment and indiscriminate disposal, less careful testing of buys, and unsafe injecting. Users and dealers moved to less policed locations, leaving users isolated if they overdosed, severing links with services, and spreading nuisance and drugs to new communities. Crackdowns also led to 'target-hardening' – professionalisation of the market and protective devices such as selling larger amounts in fewer transactions.

Taking a different approach, police in Oakland California (study ❸) established 'Beat Health' teams to generate action by local people and the authorities in neighbourhoods affected by drugs and disorder to make them less attractive to criminals. Housing, fire and safety regulations were enforced and civil law used to prompt landlords to 'clean up' premises. Teams formed relationships with 'place managers' – residents or business people whose stake in the area means they engage in informal policing. 100 street blocks referred to the teams were randomly allocated either to the teams or to conventional police units. Five months later the Beat Health blocks evidenced less drug dealing and neglect and women felt safer on the streets. Improvements were partly due to official interventions but were also associated with collective responses and social cohesion rather than individual actions such as calling the police.

LINKS *Nuggets* **1.10**

In context Generalisability of the Cabramatta experience is limited by a race dimension which complicated community support for intensive policing. However, echoes have been documented in Britain. In London a closed dealing location facilitated harm reduction interventions and avoided nuisance from street dealing. Police action against drug users found with injecting equipment is thought to have encouraged the sharing of equipment which spread HIV in Edinburgh. A Home Office review (◤ *Secondary sources*) argued that target-hardening and displacement rarely outweigh the benefits of policing and place management strategies. However, it did not take into account the potential for intensive policing to encourage unsafe drug use. One benefit of heightened risk – that some users may opt to 'retire early' – is partly dependent on treatment being available.

Practice implications ◤ *Secondary sources* for a comprehensive account. Police crackdowns on drug markets will have more enduring impacts if used to create 'space' and confidence for community action to make sites less attractive as markets. In this task the major legal tools are civil rather than criminal, such as those enabling councils to exclude dealers and requiring owners to maintain premises. Using these tools, police can help reverse the cycle of decay and crime, leading to withdrawal and neglect, and further decay and crime. Drug action teams and crime and disorder partnerships are the main vehicles for the official cooperation required but neighbourhood solidarity is an important backdrop. Beyond policing, authorised injecting venues can reduce harm to drug users and curb local nuisance. Such facilities and easier access to treatment should help 'soak up' drug users deterred by policing, reducing displacement.

Main sources ❶ Maher L., *et al*. *Running the risks*. National Drug and Alcohol Research Centre, 1998. ISBN 0 9472 2992 2. Copies through bookshops ❷ Maher L., *et al*. "Policing and public health: law enforcement and harm minimization in a street level drug market." *British J. of Criminology*: 1999, 39(4), p. 488–512. Copies: apply DrugScope ❸ Mazerolle L.G., *et al*. "Controlling drug and disorder problems: the role of place managers." *Criminology*: 1998, 36(2), p. 371–403. Copies: apply DrugScope.

Secondary sources Jacobson J. *Policing drug hotspots*. Home Office, 1999. Copies: Home Office, phone 020 7271 8225.

Contacts ❶ ❷ Lisa Maher, School of Medical Education, University of New South Wales, Australia, fax 00 61 2 9385 1526, e-mail l.maher@unsw.edu.au ❸ Lorraine Mazerolle, School of Criminology and Criminal Justice, Griffith University, Mt. Gravatt Campus, Brisbane, Queensland 4111, Australia, fax 00 61 7 3875 5608.

3.15 Family skills programmes delay adolescent drinking but recruitment is a problem

Findings Two large-scale US evaluations suggest that adolescent alcohol use and problems can be reduced by intervening not just with high-risk families but with families in general.

A programme in Iowa targets rural families with children aged 11–12. Group leaders run seven weekly sessions attended by (in study ❶) on average eight families, aiming to enhance family relationships and cohesion and improve parental rule-setting and disciplining. Children also learn social skills and how to refuse drug offers. 22 schools with 873 eligible families were randomly assigned to the programme or to act as controls; 446 agreed to participate and completed baseline measures. An earlier paper found the intervention fostered a parenting style thought to delay alcohol use among children. The current paper found that drinking had indeed been delayed. Over the next two years far fewer children from programme schools started to drink (26% v. 48%), drink without permission (17% v.39%), or get drunk (8 v.18%). However, only a third of eligible families could be included in this analysis. Families in programme schools were included whether or not they attended the sessions; about half attended at least once.

The Iowa study focused on *initiation* into drinking; study ❷ suggests family programmes affect users and non-users differently. Aims were similar to those in Iowa, but the project sought to reach more families by delivering the intervention in their homes and restricting it to three one-hour sessions when children were aged about 10 (with a booster two years later), tactics which met with only limited success. From a sample of 892, 428 children completed surveys before and after the intervention and for the next four years, but just 90 were from families who agreed to be assigned to the intervention. For children who had not already drunk alcohol (the vast majority), the programme substantially curbed increases in drinking and related problems, most clearly at the last follow-up. The reverse was the case for children who *had* drunk before, but there were so few that this could have been a chance finding.

LINKS *Nuggets* **2.13 2.15**

In context ◤ *Secondary sources* for a review of relevant research by an expert US panel. Both studies suffered badly from attrition. Results among the few families who made it through to the final analyses may be a poor guide to the programmes' appeal to and impact on other families, even those with children in the same schools. Generalising beyond white, intact mid-west families and rural locations to the rest of the USA is even more risky, still more so to the UK with its different approach to alcohol and under-age drinking. Effectively, both interventions demonstrated their effectiveness mainly among children who had not previously drunk, and virtually none of whom had drunk unsupervised. Interventions oriented more towards harm reduction may be more appropriate in cultures (such as Britain) and at ages where adolescent drinking is more common.

Practice implications ◤ *Secondary sources* for US guidelines. For non-selective family interventions the main problem is recruitment. Even cut-down, delivered-to-your-door interventions fail to attract, probably because they address potential problems most parents have yet to experience and few seriously anticipate. Making the time commitment and content acceptable to a variety of families at different risk levels encourages a 'lowest common denominator' approach which mitigates against effectiveness. Most parenting interventions instead target high-risk families where problems may already be apparent and the approach can be intensive and individually tailored. Despite these obstacles, results among families who do participate can be impressive. Especially where acceptable participation rates are possible and in relatively homogenous communities, such programmes can make a worthwhile contribution to drinking outcomes.

Main sources ❶ Spoth R., *et al*. "Alcohol initiation outcomes of universal family-focused preventive interventions: one- and two-year follow-ups of a controlled study." *Journal of Studies on Alcohol*: 1999, supp. 13, p. 103–111 ❷ Loveland-Cherry C.J., *et al*. "Effects of a home-based family intervention on adolescent alcohol use and misuse." [As ❶], p. 94–102. Copies: for both apply Alcohol Concern.

Secondary sources *Preventing substance abuse among children and adolescents: family-centred approaches.* US Center for Substance Abuse Prevention, 1998.

Contacts ❶ Richard Spoth, Social and Behavioral Research Center for Rural Health, Iowa State University, USA, fax 00 1 515 294 3613, web site http://www.exnet.iastate.edu/Pages/families/sfp.html ❷ Carol Loveland-Cherry, Child and Parent Relations Project, University of Michigan, USA, fax 00 1 734 647 1419, e-mail loveland@umich.edu.

SECOND SIGHT

Right methods, wrong objectives

A reaction from one of our expert advisers

A leading British practitioner argues that targeting drug use prevention may be just the way to miss hitting that target.

by **Adrian King**
InForm Drug Education Consultancy

Despite a US policy environment hostile to balanced drug education, Life Skills Training addresses some of the general factors – poor self-esteem, social anxiety, lack of confidence – which feed drug (and other) problems. Moreover, it has pioneered or finessed teaching methods from which we have all learnt. But basic contradictions undermine this endeavour.

The most basic contradiction is that it foists a ready-made adult decision on pupils rather than trusting them to decide for themselves. While our avowed aim may be to enhance freedom of choice and empower young people to resist manipulation, distrust of their judgement when it comes to illegal drugs, allied to society's aversion to drug use, drives a search for ever more effective ways to constrain and manipulate young people's choices. We aim to produce responsible, rational and confident adults in full control of their behaviour; drug education aimed at changing behaviour by reducing freedom of choice undermines this objective.

Young people know when they are being trusted to think for themselves – and when they are not . The older they get, the more they reject education which assumes that only manipulation and control can prevent their making the wrong decisions, and which presents them with ready-made rights and wrongs, as if we had failed them so badly that they cannot work these out for themselves.

On other sensitive issues – politics, religion, abortion – teachers employ very different strategies: identifying objectivity, ensuring factual accuracy, inviting balance, neutral 'chairing' of discussions, etc. In contrast to illegal drugs, we trust young people to decide whether to rob, rape, or mug. Too many adults commit such crimes, yet there is no drive for lessons encouraging children to 'say no' to mugging, no guidelines on anti-mugging education, no Anti-Mugging Czar to cordinate policy.

Life Skills foists a ready-made adult decision on pupils rather than trusting them to decide for themselves

From this point of view, the issue is not how we can prevent drug use, but how can we modify our aims in such a way as to convey unstinting trust in young people's abilities to develop the judgement, skills and motivation to make their own choices about their behaviour, and to take responsibility for those choices. Measures of effectiveness would then shift from the behaviour of young people, to the quality of the developmental opportunities we provide. Paradoxically, this may do more to equip them to live safely in a world where drug use and illegal activity present real dangers.

Whatever we do, many young people will continue to try illegal drugs. Educators cannot support and must not collude with this, but neither can we avoid asking what 'prevention education' does for those it fails to deter. An approach predicated on mistrust risks alienating those in greatest need. Its 'success' may be hollow indeed if it only affects those unlikely in any event to become long-term, problem users.

Dr Botvin's research presumes the desirability of preventing certain predetermined behaviours; the *National Healthy Schools Standard* launched last October recognises that we can do better than that. To respect young people enough to educate them according to the needs they themselves identify may be more effective, and invite more worthwhile criteria for success.

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Lacking directly relevant evidence, we have to fall back on what is known about how early use of alcohol, tobacco and cannabis relate to later drug problems. Some research supports a role for these as 'gateways' drugs, implying that preventing their use will also prevent later use of drugs such as cocaine and heroin, but the evidence is contested.[27] British medical bodies interpret it as suggesting that early smoking and drinking do not in themselves act as gateways, but can form part of a syndrome of conduct problems leading to deviancy of various kinds, including illegal drug use.[28]

Perhaps it is not *whether* early use occurs, but *how* early. In Britain early heroin users also tend to have been early smokers and drinkers.[29] US research has shown that delaying the onset of drug misuse – which will generally mean cannabis use – is associated with reduced risk of later problems with illegal drugs.[30] But we do not know whether early use causes later use, even less whether 'artificially' (eg, through classes aimed at this end) delaying the onset of drug use will prevent later drug problems. Absence from school and a disregard for drug education suggest that classroom lessons would not have diverted contemporary young British heroin users.[31]

The upshot is unsatisfactory uncertainty. Whether Life Skills Training – or any similar programme – can prevent drug problems is an open question, with the evidence strongest in relation to heavy smoking and drinking to intoxication. This vagueness is unlikely to be dispelled until researchers focus on later drug problems rather than adolescent drug use as their key outcomes.[32]

Are the costs justified?

Even if school programmes do cut drug problems, there are other routes to the same end which may absorb less of society's monetary fuel. Here we can draw on a cost-benefit analysis of school-based prevention from the respected US RAND institute.[33] This relied partly Dr Botvin's work precisely because it was among the most convincing demonstrations of the effectiveness of such programmes.

RAND combined Life Skills' long-term outcomes with those from another programme to estimate the savings to US society from cuts in cocaine consumption, heavy drinking, and smoking. Per $ spent, savings totalled anywhere from $1 to $9, with a best guess of nearly $4. Though comparable to estimates for enforcement, this is under half the return of $10 per $ spent on treating heavy cocaine users – and that estimate suffers from a far smaller margin of uncertainty. More positively, RAND also estimated that prevention would cost $20,000 per life saved by cutting smoking alone, well within the accepted figure for justifying health interventions.

The key factor in these calculations is that while (especially for legal and more accepted forms of drug use) anticipated use reductions from prevention are modest,[34] so too is the cost of achieving them. Administrations with US-style drug problems might still be tempted to invest instead in the more secure and greater benefits of treatment. However, RAND's estimates omit an important benefit of preventing drug problems – also preventing the unhappiness, wasted years and lost lives which often precede drug treatment, and which treatment cannot recover.

In Britain perhaps the most optimistic substance use trend has been the reduction in child deaths attributable to solvent misuse. This appears to have been as much due to supply reduction as to demand reduction measures such as drug education.[35, 36]

Cracks in the theory

When a theory-based intervention produces inconsistent outcomes and few findings support its hypothesised causal chain, a possible explanation is that the theory is wrong. Underlying most life skills approaches are theories which start with psychological deficits and underdeveloped social and personal skills, and end with the drug use these are thought to cause. A fundamental readjustment would entail moving one or both of these end points. The more fixed is the outcome end – the 'no drug use' objectives to which any officially backed US education programme must subscribe.

Life Skills' record may have been held back by a clash between its broad personal development content and these narrow objectives. Even if it produces well balanced, socially skilled youngsters, such youngsters may still try drugs.[37] Sceptics argue that drug experimentation is neither a sign of social or psychological deficits nor of an inability to resist drug offers (◤ *It's normal*). If this is the case, then targeting these 'risk' factors is bound to lead to disappointing drug use outcomes, perhaps even the opposite of what's intended.[38, 39] Had Dr Botvin been able to pursue and measure 'responsible drug use' (which in one paper he suggests is the more feasible goal[40]) he may have found more encouraging results.[41]

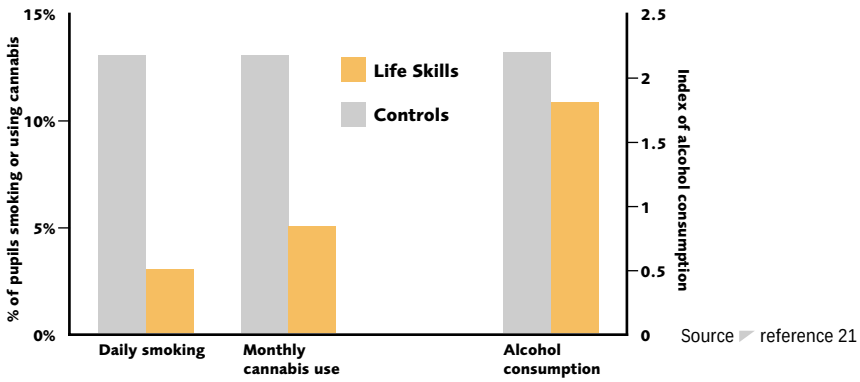
At a deeper level is the contradiction within any programme which seeks a *fixed* outcome (not trying drugs) by *widening* the scope for independent decision-making and freedom to act. Teaching drug refusal skills is teaching pupils how to implement a decision made for them, not how to make decisions for themselves. That argument is advanced by educators in Britain (◤ *Right methods, wrong objectives*) and in America,[42] with greater credibility the older are the children.

> ◤◤◤ *Even if Life Skills produces well balanced, socially skilled youngsters, they may still try drugs*

Another contradiction, which Life Skills suffers from less than other programmes, lies between the concern for child welfare purported to motivate drug prevention and the facts about the gravest threats to that welfare. These are tobacco, alcohol and motor cars, not illegal drugs, and not all illegal drugs and methods of use are equally risky.

If these structural weaknesses do undermine Life Skills' credibility with pupils, it would be no surprise that it works best where the contradictions are least – cigarette smoking. Here instead of reinforcing adult norms it challenges them, and does so clearly in the best interests of the pupils.

Some of Life Skills Training's most impressive results were recorded by peer educators after teaching the course to eighth grade pupils (age 13–14) and running booster sessions. As well as outperforming controls, they outperformed teachers.



Source ◤ reference 21

Practice implications

If we are to invest in school-based drug prevention, what does 20 years of research on Life Skills Training tell us about how to do it? Here the lessons are clear and accord with European experience: make it interactive; keep at it; use peer leaders; and don't expect too much – postponement and small reductions in the extent and intensity of drug use are more achievable than wholesale prevention of use.

Interactivity and persistence

On the evidence from Life Skills and other studies, the most important feature of effective drug education is interactivity – encouraging and responding to the two-way communication between pupils and teachers and between pupils.[43, 44] Life Skills' acceptability in suburbia and in deprived urban environments says much for its flexibility, a virtue which probably derives from highly interactive methods which reveal what pupils know, believe and feel, and enable these to be reflected in the lessons.[45]

What of allowing lessons to be led by pupils themselves? One of Dr Botvin's most thought-provoking studies was a one-year follow-up of seventh graders exposed to Life Skills Training led either by older peers or by teachers; half the schools ran booster sessions the following year.[46] *Only when basic and booster sessions had been led by peers* were there any significant reductions relative to controls in smoking, amounts drunk, or cannabis use. Some of the cuts were substantial and in relation to smoking involved every measure from monthly through to daily use. The results broadly held even when peer leaders were compared with just those teachers who had taught the lessons as intended.

On the core skills-teaching and interactivity dimensions, the youngsters may have been less inhibited than teachers versed in conventional teaching and unwilling to self-disclose to pupils for whom they held a control responsibility. Pupils are also likely to self-censor communication which might suggest to a teacher that they are unduly familiar with or interested in illegal drugs.

Peer education *may* confer benefits, but certainly carries risks – of unsound messages, classroom disorder, and lessons not being taken seriously. It works best if peer leaders are slightly older than their pupils, well prepared and supported, and supervised by adults who let them take the lead while maintaining classroom order. Dr Botvin's team made extensive efforts to meet these requirements.[47, 48]

This study also (at least for peer education) confirmed the role of 'booster' sessions in the two years following the basic course, which an earlier study had found to roughly halve the rate at which pupils moved to weekly or daily smoking.[49]

SECOND SIGHT

It's normal

by **Rodney Skager**

Graduate School of Education and Information Science, University of California, Los Angeles. Professor Skager teaches adolescent development, writes on prevention issues and has directed the California Student Survey which monitors substance use and related information

A challenge to the most fundamental assumption made by Life Skills Training – that personal and social deficits lead to drug use.

For at least two decades substance use has been normalised among American adolescents. 'Normalised' implies more than statistics such as that 75% or more of 16-year-olds have tried alcohol and over half marijuana. Substance use is embedded in the teen social scene, the shared experience of users and non-users, many of whom accept contact with drugs as normal. Within this context drug prevention education has failed because it is based on three false assumptions about adolescent development.

The first is that young people try drugs because they are ignorant of the consequences. In fact, they have direct information from observing other people and the experiences of themselves and their friends. This is why unreal, exaggerated anti-drug indoctrination fails. Early prevention messages are forgotten or contradicted when teens enter secondary school, when newly matured powers to question and construct alternative views mean that what adults say is no longer taken for granted.

The second assumption is that adolescents use substances to erase negative feelings caused by personal deficits. Given the pervasiveness of substance use, this virtually amounts to an assertion that there is something wrong with adolescents in general. At first it was assumed they were deficient in self-esteem; now that they lack social and life skills.

Most teens say children try drugs because they are curious or to have fun. Curiosity and wanting to have fun are normal motives – even for some adults – and do not reflect personal deficits. Rather than lacking social skills, most children learn very well how to get along in their own social world, constructing an outside-the-home identity which has survival value in the peer social context where they spend their time and into which they project their future.

It's assumed that kids are ignorant, deficient, and pressured by friends. All three are wrong

In this world drinking or using drugs is to participate in a ritual relevant to group identity and therefore relevant to the child's own sense of self. The meagre and highly qualified results achieved by life skills programmes are thus exactly what we would expect.

The third false assumption is that children use drugs because peers pressure them to do so. Research in the USA and Britain suggests children spontaneously imitate what they know or believe their peers to do without having to be pressured. Given the normalisation of substance use, initiation into drugs is more accurately understood as spontaneous modelling of behaviours seen as normal or 'cool'.

Helping children who **are** deficient in social and living skills is fine. But most who experiment with or use substances occasionally are functional citizens of their own social world. Deficit-oriented programmes administered across the board waste the resources of hard-pressed schools and are unlikely to survive without outside pressure and resources. A reinvented prevention would instead emphasise interactive and participatory learning in which the experience of young people is valued. The nature of the relationship between youth and teachers or facilitators would be primary, more significant than the content itself.

Based on a seminar presentation "Reinventing Drug Prevention Education for Adolescents" as summarised at a conference sponsored by the Association of the Bar of the City of New York, the New York Academy of Medicine, and the New York Academy of Sciences in New York on 17 March 2000. Full presentation with supporting references available from Professor Skager, e-mail rskager@redshift.com.

Right for Britain?

In some ways Life Skills Training fits the British tradition in personal, social and health education. In others it is clearly the product of a culture whose distinctness is masked by a shared language.

Features which would sit easily in Britain include Life Skills' insistence on tackling drugs in the context of adolescent personal and social development, the emphasis on skills rather than knowledge, and its placing of legal drugs on a par with illegal. The UK drug policy target of implementing lifeskills approaches in all schools by 2002 "based on evidence of good practice"[50] makes the programme ripe for importation: there is only one off-the-shelf teaching package with 'Life Skills' in its title and at its core, and that one has an evidence base broader than any other.

However, rather than the structure and content of lessons, European health educators emphasise open communication based on a trusting, respectful relationship between teacher and taught, and prefer to see their role as offering opportunities for pupils to develop in ways not prescribed in advance and peculiar to each individual.[51] Life Skills' prescriptiveness – its set if modifiable content and predetermined outcomes – is alien to this agenda.

This prescriptiveness derives partly from America's more absolutist approach to drug use, reflected in policies which constrict the range of acceptable prevention objectives. Whatever Life Skills' ranking within the US drug education field, it is a limited field. The greater scope given European schools must bring other contenders into the frame.

For American under-21s alcohol is an illegal drug; in theory and even more in practice, for much younger Britons it is not, making 'responsible' use a practical objective – perhaps one reason why alcohol-specific interventions seem to work best.[52] Reinforced by federal regulations, prevention in the USA and the response to drug incidents at school are pervaded by zero tolerance attitudes[53] which must limit the scope for open communication between pupils and teachers, especially pupils considering or already using drugs illegally. Even with respect to illegal drugs, prevention in Britain is understood (though not openly) as having a high harm minimisation content, evident in the attempt to foster help-seeking and help-giving skills.

Among illegal drugs, Life Skills' focus on marijuana seems out of sync with UK priorities, now shifting towards preventing serious problems related to heroin and cocaine,[54] most of all drug-related crime. Dependent use and crime are concentrated among the psychologically and/or socially disadvantaged, and then just a small minority;[55] universally applied programmes are unlikely to be a cost-effective antidote

Education is not the same as prevention

Drug prevention aims to prevent substance use. Prevention may be primary – intercepting the development of drug use before it has started; secondary – stopping use which has started; or tertiary – reducing the extent and frequency of use, and possibly diverting users to less damaging substances and forms of use. Drug prevention is **against** substance use.

Drug education is intended to inform students about facts, contexts and consequences related to substance use. It includes the transmission of facts and information, discussion of this information, and opportunities to reflect on attitudes to the information and to the behaviours involved. Drug education is **about** substance use.

The hybrid term **drug prevention education** is confusing and contradictory. While not denying the links between education and prevention, British practitioners increasingly argue that an intervention which has a fixed intended outcome (ie, preventing certain behaviours) cannot also be accurately described as educational. In the latter the emphasis is on understanding and discussion, not behaviour change, and personal autonomy is acknowledged.

LINKS
The danger of warnings. *Findings* issue 1, p. 22–24.
Teaching in the tender years. *Findings* issue 1, p.4–7.
Nuggets 1.11, 1.12.

Do we need a programme?

Whatever the virtues of Life Skills Training, are universally applied school programmes of any kind the way to prevent drug problems? One view is that while **education** about drugs can and should be universal, **prevention** should be far more targeted and flexible.

The advantages of a set programme relate mainly to quality control. If a proven, high quality programme is implemented as intended by able and well trained teachers, schools and parents can feel confident that at the worst it will not backfire and that prevention effects are likely. A good programme will incorporate mechanisms to mould it to the pupils whilst ensuring that key inputs are effectively delivered, reducing performance variability between teachers. Schools under pressure to meet drug policy targets can clearly show they are doing something and justify it on scientific grounds.

The counter-argument is based on the fact that most children do not use illegal drugs and very few become problem drinkers or drugtakers. Perversely, while universal prevention programmes hit many who do not need intervention, they miss many who do. Serious drug use in adolescence is often accompanied by truancy, school exclusion and a disdain for drug education. In this vision what schools need is not a universal prevention programme, but **mechanisms to pick up on the atypical few** at serious risk (who will often manifest a range of behaviour problems) and then suitable people and services to refer them on to for individualised help.

Given its prevalence, the likely escalation in use once started, and the resultant health damage, advocates of targeted prevention might make an exception for tobacco. From this perspective there is a case for Life Skills Training to return to its roots – the prevention of smoking.

(◤ *Do we need a programme?*). In the adolescent years themselves, preventing dangerous forms of solvent and stimulant use are probably more of a priority than cannabis.

Life Skills is most thoroughly proven in its impact on smoking, the form of drug use associated with the greatest damage, but not the one highest on the public's agenda. Also its content is mostly about fostering general adolescent development, a tack which might lack appeal for parents and politicians keen to see children 'taught' not to use drugs.

Such considerations raise questions over Life Skills' portability to Britain, as do social differences, especially with respect to race. Within Britain the US association between racial minorities and (known) problem drug use is not replicated, and claims for Life Skills suitability for minorities rest heavily on studies of Latino pupils.

Beyond content and style, the biggest question mark over Life Skills' potential role in the UK is the demands it makes on teachers and on the school timetable.

Demands outstrip resources

Though considered good practice, Life Skills' extended inputs led by regular teachers mean schools pressured to deliver academic results will be pushed to implement it in full. Its 30 45-minute lessons straddle key stage three, the years under greatest pressure from the statutory curriculum and where OFSTED inspectors found drugs teaching reached its nadir, often being relegated to tutorial lessons.

Following the report which in 1997 delivered that verdict,[56] little seems to have been done centrally to monitor and improve drug education. Demands and expectations are high, but have not been matched by statutory obligations or resources. Inevitably short cuts will be taken whose main attractions are price and minimising the load on teachers rather than quality.

Adequate resources are not in themselves enough; teaching styles and abilities are critical. Interactive teaching – integral to Life Skills – makes heavy demands on classroom management. Teachers must themselves possess good life skills and feel comfortable about allowing children leeway to interact on the contentious topic of illegal drugs. Life Skills' training should help, but requires teachers to be released for two days. Even among teachers trained by Dr Botvin's team, few have the "skills, confidence or motivation to teach the ... skills training components";[57] "selecting high quality teachers" may be needed.[58]

The resource implications are substantial and perhaps unrealistic. An officially acknowledged shortage of teachers trained in drug education[59] is unlikely to be turned round in the near future. Latest guidance on initial training[60] omits an earlier call[61] for a grounding in drug education, and in their general content the courses major on knowledge rather than teaching skills such as active learning.

In-service training might help but is vulnerable to competing priorities. The £7 million per year Drugs Prevention Standards Fund is now incorporated in a Social Inclusion Fund. There is no obligation to spend this money on training, or even on schools, and the requirement that local authorities match spending £ for £ could deter some.[62] Previous drug training grants failed to benefit over 8 in 10 schools.[63]

Beyond frontline teachers are the heads, school governors, local education authorities, politicians and schools inspectors who provide the resources and set the parameters within which teachers feel able and motivated to teach, and outside of which they feel vulnerable. To sustain a life skills programme, teachers need to feel confident of their support and that the school values this kind of work.

In its favour, there is far more to Life Skills Training than drugs. Much of it could double as a personal and social skills curriculum and its teaching methods (rather than the detailed programme) could inform

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Copies: for both apply DrugScope, phone 020 7928 1211.

For the curriculum contact: Steven A. Brod, Princeton Health Press, Inc., 115 Wall Street, Princeton, NJ 08540, USA, fax 00 1 609 921 3593, e-mail PHPInfo@aol.com, web site http://www.lifeskillstraining.com.

For the developer contact: Dr Gilbert J. Botvin, Institute for Prevention Research, Cornell University Medical College, 411 East 69th Street, Room 201KB, New York, NY 10021, USA, fax 00 1 212 746 8390, e-mail gjbotvin@aol.com.

and improve drug prevention and education in Britain. Helping to legitimise the required investment will be the new non-statutory framework for personal social and health education, which incorporates legal and illegal drugs.[64] The *National Healthy Schools Standard* signifies a revived concern for fostering personal growth and autonomy and the acceptance of responsibility among pupils. If schools can be allowed to follow such an agenda rather than being pressured to deliver unrealistic drug use outcomes, there may yet be a role for what after all are the most distinctive elements of Dr Botvin's approach – its teaching methods and its holistic approach.

A fully referenced and more extended version of this paper is available by e-mail from findings @mashton.cix.co.uk.

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Gone but not forgotten

*The theory and practice of **outcome monitoring**. Overleaf, two alcohol projects tell how they overcame the obstacles and tested their performance against the bottom line – what happens to clients when they leave. On this page, a commentary from FINDINGS concludes there is no substitute for post-treatment follow-up.*

If service management is a cycle beginning with plans, moving through implementation to evaluation, which feeds back into planning, there is usually one major gap – knowledge of what happens to clients when they leave. On the next two pages Accept and WACS show that even for small services, this gap is not inevitable. They found what the research also indicates: there is no reliable substitute for long-term follow-up.

Client satisfaction is an important quality measure in its own right[1] and can relate to discharge status.[2] However, it is not a proxy for longer term outcomes, not even necessarily an indicator of who will stay the course.[3, 4] Good attendance at treatment sessions and completing the programme – aspects of treatment compliance – are more promising indicators of longer term success, but the links can be loose.[5, 6] How people do during treatment may be a guide to their later welfare, but the intensive therapies that most need justification – especially residential options – provide so much support that how people do while they are there is a poor guide to how they will manage on their own.

Surely we can simply replicate what we know works from previous evaluations? There are two problems. First, studies rarely describe the treatments and those found to benefit in sufficient detail for all the elements to be replicated. Second, the influence of the therapist and other factors[7] is such that what worked before may flop with new staff in a different setting.[8, 9]

A combination of implementing proven strategies, assuring staff deliver the intended inputs at high quality, and monitoring treatment completion rates, may stand in for outcome monitoring. As long as ❶ what works elsewhere also works at your service ❷ you have the right idea about what counts as 'quality' ❸ your clients stay the course because they really have turned away from drink. It might be as well to check.

There is some good news. Drinking outcomes in the first year after treatment have been found to predict outcomes in later years – not perfectly, but consistently.[10] So a single reasonably comprehensive follow-up effort around 12 months after treatment may be enough. If these outcomes can be micro-related to different inputs – such as which therapists worked with the client, how they related to them, what services were provided, and aftercare arrangements – then you have a powerful tool for improving the service.

Same aim, different methods

Even if the *desirability* of collecting outcome data is recognised, feasibility may be questioned. The difficulties have led some to counsel against the attempt unless provider arms are severely twisted by purchasers.[11] This may be too pessimistic. Though probably very much in the minority,[12] Accept and WACS have shown that follow-up can be managed, even by small agencies.

Their approaches share common features. Both avoid repeated contact attempts by assuming that non-responders are doing badly. This risks missing people not in stable accommodation, but it does make follow up more feasible. And the assumption has support from research which showed that ex-clients who had to be chased to get them to respond were doing worse than those who responded to the initial contact.[13]

Both services make it easy for ex-clients to respond and for the agency to analyse the data by stripping questions down to those most relevant to treatment goals. For both this dictated abstinence as the primary measure; services aiming for less harmful drinking would face the more difficult task of gathering data on the harms they were targeting and then deciding what counts as success if these reflect a mixed picture. Finally, both agencies see follow-up as an opportunity for ex-clients in need to receive further support.

Beyond these important parallels, their systems could hardly be more different. Accept's mailed questionnaire facilitates anonymity while at WACS a counsellor phones the ex-client. WACS cuts down workload by sampling while Accept contacts all clients but makes this manageable by the simplicity of a mailshot.

Clearly these options do not exhaust the possibilities, but they do demonstrate that such work is feasible and seen as valuable by agencies which undertake it. Their methods might not past muster in academia and the lack of standardisation is an obstacle to service planning based on comparative performance as well as raising question marks over the validity of the outcomes. Neither do they function perfectly as a safety net for ex-clients in trouble. However, they are practical – and a great deal better than trusting to luck.

References and further information sources page 25

Golden Bullets

Essential practice points from this article

- Even small services can manage a routine client follow-up system which they and their funders value.
- Benefits include ❶ assessing performance ❷ improving effectiveness ❸ enhancing staff morale ❹ bolstering purchaser support ❺ contacting former clients in need of help.
- If you want to influence stakeholders, develop the system with them. Added bonus – perhaps they will fund a system which delivers the data they want.
- To improve effectiveness you'll need to connect outcomes with inputs. That means also recording what was done with which clients.
- Keep it simple. Use occasional more thorough follow-ups to check your routine system.
- Be clear about your key treatment goal. Measure that, then see what else (if anything) you can do.
- Use standard outcome measures if they will do the job. Then you can compare your outcomes against established benchmarks and against other services.

It's good to be jolted

by **Barbara Elliott**

At the time of writing, Director of Accept Services, a day centre in West London offering abstinence and controlled drinking services

Measuring what happens to clients while they are with you and when they leave is a crucial starting point for improving services. If we fail to do so, while advocating change in our clients, we avoid one of the main motivators of change for ourselves and our agencies – the jolt of finding out how clients *really* do when they leave. Commissioners too increasingly demand evidence of effectiveness, especially for intensive or long-term treatments.

So why is follow-up monitoring so rare? Get-out clauses include 'limited resources' and 'respecting client privacy'. Our experience is that neither hold water. Without noticeable client resistance, Accept has implemented routine follow-up with a small team of three clinical workers and three part-time volunteers.

Clients of Accept who opt for abstinence design their own day programme and work in the groups they choose for anything between six weeks and six months depending on how they feel they are doing. During this time the number of weekly sessions tapers until (ideally) they spend the last year or two attending a weekly evening aftercare group. In a typical week up to 24 clients attend the day programme and 30 or more the aftercare groups. The follow-up system applies only to these clients.[1]

Who to follow up?

Assessing how people are doing six or 12 months after leaving comes at the end of a series of data collection points. From our office register we identify those who *fail to engage* (leave during first two weeks) and *drop-outs* (unplanned leavers after the first two weeks). We also monitor *attendance* in the aftercare group.

From this data we know that about one in eight new clients fail to engage. Half of the remainder leave the day programme at between eight and 30 weeks after having completed their plan; most then move into an evening aftercare group. The other half generally drop out unplanned and do not resume contact in response to two letters inviting them back.

In estimating longer term outcomes we err on the side of caution by assuming that drop-outs are not doing well. By virtue of attending aftercare or for other purposes, many clients stay in regular contact after completing the day programme, so their drinking status is known. Only planned leavers no longer in regular contact need to be followed up using our postal system.

This consists of a simple tick box questionnaire with an addressed and stamped return envelope. Recipients can choose whether or not to return it anonymously. The SAE is more than a courtesy; I feel it is largely responsible for the high response rate. All clients are contacted between six and 12 months after they started the day programme; some who started earlier are also re-contacted. For the purposes of the statistics, we assume that non-responders are struggling with their drinking.

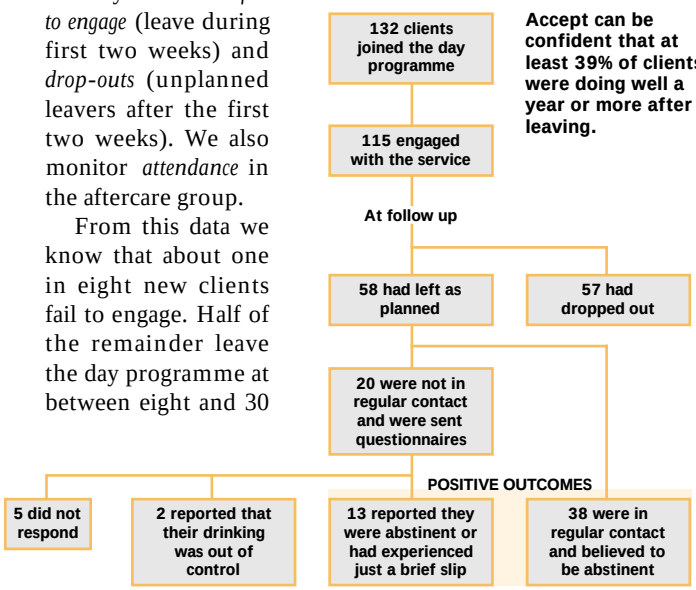
What to ask?

Our aim is simply and quickly to gain a snapshot of what happens to clients after they leave. Far from seeing it as an intrusion, most respondents seem pleased to tell us how they are doing, often adding notes and messages. Some who *don't* respond may be less pleased, but so far we have received no complaints. For both sides the procedure is extremely simple: a few hours work for Accept, a few minutes ticking boxes for the client.

The focus is on a concrete, self-reported behaviour – drinking alcohol. Life's other problems do not always improve when such drinking stops, but it's a fair assumption that most clients who aimed for abstinence and who later achieved it will have also improved across the board. This means the returns can be categorised simply by the degree to which drinking outcomes have fallen short of abstinence. The categories we use are:

- maintained abstinence since last seen;
- experienced 'learning curve slips' but now abstaining;
- experienced full-blown relapses;
- now drinking, either uncontrollably or in a controlled manner.

Outcomes at the end of 1998 for clients who had entered the day programme between January 1996 and June 1998 (chart) suggested that at least 44% who had engaged with the programme were abstinent or near abstinent. To this could be added an unknown number of drop-outs and non-responders who were nevertheless doing well, bringing the probable success rate to 1 in 2. Among those who engage with the service, abstinence rates over 30% make me think we must be moving in a positive direction.



Feedback affects practice

Our methodology may lack precision, but it is an easy, quick and inexpensive way to gain feedback on whether our intervention was useful. Fail-safe assumptions about drop-outs and non-responders leave the honesty of responders as the main question mark. However, there is plenty of evidence that people tell the truth about their drinking when they have nothing to gain from lying. In this case the responders are no longer our clients and can respond anonymously; probably most are truthful most of the time. Of course, *if they are equally suitable*, standardised instruments are preferable to custom solutions. But when we set up the system none *were* suitable. Measurement tools such as the Maudsley Addiction Profile have since become available.

What influence do the results have? Strangely, service commissioners do not seem to pay much attention. However, the results do have a great impact on the staff team and on its practices, helping us assess whether promising innovations really do translate into better outcomes.

CONTACT

Accept Services (UK), 724 Fulham Road, London SW6 5SE, phone 020 7371 7477

1 Another 15 to 20 clients a week work on controlled drinking goals. The high turnover in this programme precludes (with current resources) systematic follow-up.

Gone but not forgotten

Simplicity gets the job done

by **Fiona Dunwoodie** *and* **Jo Blackledge**
Business Manager and Senior Counsellor at the Waltham Forest Alcohol Counselling Service (WACS).

The Waltham Forest Alcohol Counselling Service (WACS) provides a full-time abstinence-based programme of group therapy and individual counselling for problem drinkers and their families. Clients commit to attend every weekday for at least two weeks. The programme is intensive, but it was not so much the expense as our methods which prompted us to assess long-term outcomes. Abstinence is often an unpopular basis for treatment; pressured by funders to provide alternatives, we sought to defend our programme by showing that – for our severely addicted clients – abstinence was appropriate, and that our programme effectively achieved and maintained it. The only convincing way to do this was to follow up clients no longer under the protection of the day programme.

The procedure we use was introduced by a consultant hired by the local health authority to assess the service. She sampled clients seen during a randomly selected month from the previous year; it happened to be September, the month we still sample to maintain comparability.

The system's beauty is its simplicity. Everything is done over the phone. Each September we collate the phone numbers of clients who attended during the previous September, whether or not they completed the minimum two weeks. In practice, very few leave early – 49 throughout the latest year. We exclude those who were assessed but did not join the programme, either because they dropped out or were referred elsewhere, roughly three a month.

Our senior counsellor makes the calls; sometimes several attempts are needed. Problems arise when numbers change, but in that case addresses too will normally be out of date, and our experience is that phone calls generate a higher response rate than postal questionnaires. Some agencies might prefer non-clinical staff to make the calls; we reason that the counsellor's personal relationship with clients means they are more likely to be open and responsive.

CONTACT

WACS, 1 Beulah Road, London E17 9LG, phone 020 8509 1888

Funders impressed

The calls are casual and friendly. We always ask if the client is drinking, but beyond that probe how they are doing in ways which make sense for that client at that time. The fact that one person makes most of the calls probably helps prevent significant inconsistencies.

Though abstinence is the treatment goal, 'success' for us embraces not just abstinence but any positive gains – a return to work, improved family relationships, alcohol no longer posing problems, or a relapse reversed. Those we are unable to contact are not counted among our successes; this may underestimate the success rate but does ensure that it is never over-optimistic.

Perhaps because of the relaxed approach, even drinking clients have not reacted aggressively to the calls; normally they are glad to hear from us and forthcoming about how they are progressing.

Follow-up is one way we pick up on clients in need of further support, and several have subsequently returned to the programme. But, of course, it only reaches those attending in September. All former clients are also contacted by post twice a year, providing further openings for those in trouble to return to the project.

Convincing the purchasers was the major motivation for setting up the system and in this respect it has paid dividends. Our annual follow-ups have shown that the service really does work. A year later 35 of the 43 clients who attended in September 1997 had remained abstinent, three were back drinking, and five could not be contacted. Combined with user satisfaction surveys, follow-ups also form a solid basis for WACS to 'self assess', providing an overview of our success rates while the surveys highlight how the programme might be improved. We now have enough experience to convince us that such monitoring is an effective way of gauging what works and what doesn't – one which ought to be considered by every alcohol agency.

Gone but not forgotten

SECOND SIGHT Reactions from two of our expert advisers

Assure quality and outcomes will follow

by **Mike Blank**
Director, Surrey Alcohol and Drug Advisory Service

These agencies have done well to identify and follow up people to find out if they responded to interventions, but the reluctance of others to do so is in some ways understandable. Evidence suggests that people who complete programmes or respond to brief interventions show positive outcomes in terms of abstinence or controlled drinking. This means that an agency which can show it is using tried and tested interventions can also be confident that a significant number of clients who complete their programmes will do well. The issues to be addressed by purchasers are therefore quality standards and quality assurance, not necessarily follow up.

Resources devoted to following up programme completers might be better deployed in assertive outreach for those who disengaged or failed to engage. They are more likely to be in trouble with their substance use and to have mental health or other problems and should be chased up and helped to re-engage.

Walk before you run

by **Dima Abdulrahim**
Substance Misuse Advisory Service (SMAS)

Providers and commissioners would be well advised to consider their monitoring and evaluation needs as a whole before rushing into post-treatment outcome monitoring. Few monitor treatment outcomes in any meaningful way – many do not even monitor what they do – so commissioners often have little knowledge of who the clients are and which groups are under-represented. Before taking on advanced monitoring, providers need to develop basic activity monitoring and familiarise themselves with the differences between outcome monitoring, activity monitoring, client satisfaction surveys, and other feedback mechanisms.

The other reason for caution is that SMAS has seen cases across the country of instruments developed to measure outcomes, which in reality measured something else, or nothing at all. Standard instruments are preferable – but collecting such data is of little use unless you also have the skills to make sense of it.

If longer is better for drug users, why not for drinkers?

Dear Editor

Reading the last issue of FINDINGS I was struck by the divide between recommendations for treatment duration for users of alcohol compared to other drugs.

In the NTORS article there seemed to be a clear overarching theme that retaining drug users in treatment was linked to positive outcomes,[1] a theme echoed strongly in Philip Bean's article on coerced treatment which quoted evidence suggesting that "Length of exposure to treatment ... powerfully predicts [success] no matter what the treatment setting".[2]

Yet in the very same issue, "How brief can you get?", reviewing brief interventions for alcohol users, espoused the long accepted view that "More treatment input does not always equate to better treatment outcomes".[3]

I am, of course, simplifying the divide between the two positions. The articles relating to drug treatment made it clear that duration is not the only factor, while that on brief interventions for alcohol users states, "there is no research justification for denying intensive support to drinkers with severe alcohol ... problems".

However, the divide is marked enough to be of great interest and I was led me to ponder the reasons behind it. One possibility is that alcohol users who present for treatment are seen as having less entrenched and severe difficulties. But although some drinkers do present in the early stage of their drinking careers (as do drug users), the three studies featured in the brief interventions review ensured that their subjects were heavy and dependent drinkers.

I would be interested to hear other readers' opinions on this issue, especially how they interpret the evidence base in relation to problem users of *both* alcohol and other drugs – particularly relevant since the disappointing alcohol use outcomes in NTORS (and the US equivalent DATOS) raise questions over drug services' performance on this measure.

Colin Bradbury

Research, Outcome Monitoring and Evaluation Manager, Alcohol and Drug Services, 87 Oldham Street, Manchester M4 1LW.

Missing from the drugs field yet central for alcohol: the brief interventions conundrum

I was struck by the divide between recommendations for users of alcohol compared to other drugs

1 Ashton M. "NTORS." *Drug and Alcohol Findings*: 1999, 2, p. 16–22.
2 Bean P. "Pressure pays." *Drug and Alcohol Findings*: 1999, 2, p. 4–7.
3 Drummond C., *et al*. "How brief can you get?" *Drug and Alcohol Findings*: 1999, 2, p. 23–29.

"How brief can you get?" author explores the evidence on drugs

In his letter prompted partly the FINDINGS article I co-authored on brief interventions for alcohol users,[1] Colin Bradbury has highlighted a gap in the literature and provided an opportunity to address some common misinterpretations of the research evidence.

Evidence for drugs patchy

As Colin points out, in the alcohol field brief motivational interventions have been widely studied and there is good evidence for their efficacy. There has been very little similar research on drug misusers,[2] yet there is no evidence to suggest that problem drinkers presenting for treatment have less severe or entrenched problems than drug misusers.

One study found that after a brief motivational intervention, methadone maintenance patients had fewer drug-related problems and a greater commitment to abstinence (the contrast was with an educational control condition), but no differences were seen on some outcomes, including opioid dependence.[3] Two studies found benefits from brief interventions with long-term benzodiazepine users, including up to a two-thirds reduction in drug use.[4, 5]

As in the alcohol field, the evidence from randomised controlled trials (such as it is) is mixed in relation whether more intensive counselling interventions are more effective than less intensive interventions for treatment-seeking drug misusers. With some exceptions, there is no clear advantage for more intensive therapy. However, compared to the alcohol field the research base is underdeveloped and none of the studies was conducted in the UK, so the findings may not apply here.

In the context of methadone maintenance, two intensive, structured therapies (cognitive behavioural and supportive expressive psychotherapy) have been compared with basic drug counselling. At the 12-month follow-up they led to better outcomes in terms of drug use, crime, employment and psychological symptoms; more psychotherapy appeared better than less.[6]

For both alcohol and drugs the evidence does not support denying intensive treatment to people with severe or complex problems

However, a later study by the same group matched supportive expressive psychotherapy and drug counselling for intensity (time input by the therapist), yet still found an advantage for the more structured therapy.[7] In other words, the differences seen in the earlier study could be due to the *type* of therapy rather than its intensity. Consistent with this interpretation, another study found no advantage for intensive individual psychotherapy over "low contact" counselling[8] and another no difference between twice weekly cognitive behavioural sessions and a more intensive five day a week day programme.[9]

One randomised controlled trial involving methadone maintenance clients did find that at the six-month follow-up more intensive psychotherapy was associated with better outcomes.[10] Three intensities were tested from minimal input to an "extended" behavioural intervention incorporating additional "professional and vocational services". However, it is unclear whether the results were solely due to the intensities of the treatments, or also/instead to their relative quality.

Often misinterpreted

One common misinterpretation of the research evidence is to assume that variation in treatment *compliance* can be used to test treatment *intensity*. In both NTORS and DATOS, clients retained in treatment for longer were self-selecting, rather than being randomised to treatments of different intensity or duration. Better outcomes among those who stayed longer could be accounted for by factors such as greater motivation or

old gold **How brief can you get?**

Colin Drummond and **Mike Ashton** on the three pioneering British studies which topped international alcohol treatment rankings. All three dealt with brief interventions. Along the way researchers **Griffith Edwards**, **Jonathan Chick** and **Paul Wallace** explain what their studies meant to them. Drug specialists might **ponder** why there is no similar body of work relating to illegal drugs.

From the last issue of FINDINGS. 'Ponder' Colin Bradbury did (top), prompting Colin Drummond (bottom) to summarise what little is known about brief interventions for drug users.

LETTER LINE

Send letters to The Editor, Drug and Alcohol Findings, 10 Mannock Road, London N22 6AA, England, fax on 020 8888 6277, or e-mail findings@mashton.cix.co.uk. To talk over your letter first phone Mike Ashton on 020 8888 6277.

better prognosis rather than the intensity of treatment. This is why randomised trials are so important: they ensure that as far as possible patients in the different samples are matched in terms of key factors predictive of outcome, including motivation.

Another common misconception, highlighted in the FINDINGS article[11] and in earlier reviews,[12, 13] is that brief alcohol intervention and intensive treatment studies are comparable. Typically (though not exclusively), brief intervention studies involve minimally dependent, early stage excessive drinkers, identified through screening programmes. In contrast, intensive treatment studies typically involve patients seeking treatment for severe alcohol dependence. Also such studies usually exclude more complex, problematic patients, so we cannot presume the results will generalise to the wider treatment population.

For both these reasons the evidence does not support the denial of intensive treatment to people with severe or complex alcohol problems. The same appears to be true of drug misuse.

There is definitely a need for more research on the effectiveness of brief interventions for illicit drug misusers. As is often the case, the absence of evidence may be due to the absence of research rather than the ineffectiveness of the interventions. As they have for alcohol misuse, brief interventions may yet find an important place in the overall treatment response to illicit drug use.

Colin Drummond

Psychiatrist specialising in alcohol treatment at St George's Hospital in London and co-author of "How brief can you get?" in FINDINGS issue 2.

1 Drummond C., *et al*. "How brief can you get?" *Drug and Alcohol Findings*: 1999, 2, p. 23–29.

2 Heather N. "Interpreting the evidence on brief interventions for excessive drinkers: the need for caution." *Alcohol and Alcoholism*: 1995, 3, p. 287–296.

3 Saunders B., *et al.* "The impact of a brief motivational intervention with opiate users attending a methadone programme." *Addiction*: 1995, 90, p. 415–424.

4 Cormack M.A., *et al.* "Evaluation of an easy, cost effective strategy for cutting benzodiazepine use in general practice." *British Journal of General Practice*: 1994, 44, p. 5–8.

5 Bashir K., *et al*. "Controlled evaluation of brief intervention by general practitioners to reduce chronic use of benzodiazepines." *British Journal of General Practice*: 1994, 44, p. 408–412.

6 Woody G.E., *et al*. "Psychotherapy for opiate addicts: does it help?" *Archives of General Psychiatry*: 1983, 40, p. 639–645.

7 Woody G.E., *et al*. ("Psychotherapy in community methadone programs: a validation study." *American Journal of Psychiatry*: 1995, 152, p. 1302–1308.

8 Rounsaville B.J., *et al*. "Short-term interpersonal psychotherapy in methadone maintained opiate addicts." *Archives of General Psychiatry:* 1983, 40, p. 629–636.

9 Avants S.K., *et al.* "Day treatment versus enhanced standard methadone services for opioid dependent patients: a comparison of clinical efficacy and cost." *American Journal of Psychiatry*: 1999, 156, p. 27–33.

10 McLellan A.T., *et al*. "The effects of psychosocial services in substance abuse treatment." *J. of the American Medical Association:* 1993, 269, p. 1953–1959.

11 Drummond C., *et al*, 1999, op cit.

12 Heather N., 1995, op cit.

13 Drummond D.C. "Alcohol interventions: do the best things come in small packages?" *Addiction*: 1997, 92, p. 639–645.

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1 Metrebian N., *et al*. "A model of consumer audit for substance misuse services." *Journal of Substance Misuse*: 1997, 2, p. 222–227.

2 Holcomb W.R., *et al.* "Outcomes of inpatients treated on a VA psychiatric unit and a substance abuse treatment unit." *Psychiatric Services*: 1997, 49(5), p.699–704.

3 McLellan A.T., *et al*. "Patient satisfaction and outcomes in alcohol and drug abuse treatment." *Psychiatric Services*: 1998, 49(5), p. 573–575.

4 Georgakis A., "Why clients should evaluate treatment." *Addiction Counselling World*: January/February 1997, p. 10–13.

5 Stark M.J. "Dropping out of substance abuse treatment. A clinically oriented review." *Clinical Psychology Review*: 1992, 12, p. 93–116.

6 Mattson M.E., *et al*. "Compliance with treatment and follow-up protocols in Project MATCH: predictors and relationship to outcome." *Alcoholism. Clinical and Experimental Research*: 1998, 22(6), p. 1328–1339. A year after treatment in Project MATCH, whether clients achieved abstinence was at best only weakly related to treatment compliance.

7 Tucker J.A, *et al*. "Resolving alcohol and drug problems: influences on addictive behavior change and help-seeking processes." In: Tucker J.A., *et al, eds. Changing addictive behavior*. Guilford Press, 1999, p. 99.

8 Project MATCH Research Group. "Matching patients with alcohol disorders to treatments: clinical implications from Project MATCH." *Journal of Mental Health*: 1998, 7(6), p. 596. Project MATCH was unable to prevent a few of its highly trained and supervised therapists delivering outcomes "significantly worse" than their colleagues.

9 Connors G.J., *et al*. "The therapeutic alliance and its relationship to alcoholism treatment participation and outcome." *Journal of Consulting and Clinical Psychology*: 1997, 65(4), p. 597. "Even in the context of the same treatment protocol", results seen at one project might not be replicated at others.

10 Maisto S.A., *et al*. "Twelve-month abstinence from alcohol and long-term drinking and marital outcomes in men with severe alcohol problems." *Journal of Studies in Alcohol*: 199, 59, p.591–598.

11 Burns S. *A DIY guide to implementing outcome monitoring.* Alcohol Concern, 1997, p. 25.

12 Ranzetta L. *Alcohol day services in London*. GLAAS, 1999.

13 Stinchfield R., *et al*. "Hazelden's model of treatment and its outcome." *Addictive Behaviors*: 1998, 23(5), p. 669–683.

For more information on outcome monitoring

- **How to show treatment works** by Don Lavoie in FINDINGS issue 1, p. 25–26. A commissioner's view on performance monitoring.
- **A DIY guide to implementing outcome monitoring** by Sara Burns, Alcohol Concern, 1997. Advice on outcome monitoring tailored to alcohol service providers.
- **Outcome-based evaluation of alcohol misuse services. A paper for purchasing authorities.** Advice from Alcohol Concern for alcohol service commissioners.

Copies: for all apply Alcohol Concern, 020 7928 7377.

Which outcome tool should you use?

Outcome monitoring must be made easy

Dear Editor

Outcome monitoring has been a theme in both (excellent) editions of FINDINGS.[1,2] Still it needs examining in more detail in the context of services without the luxury of the support of professional researchers.

A few years ago increased referrals to our community drug team led us to seek a formalised initial assessment tool which could later be used to gauge improvements. We examined three: EuropASI; the Maudsley Addiction Profile (MAP); and the Christo Inventory for Substance Misuse Services (CISS).

EuropASI is a European version of the US Addiction Severity Index. Completing this highly formalised questionnaire can take 45 minutes, but it is comprehensive and provides scores for several problem areas. The information summary is clear and priorities for action easily identified.

MAP is also multi-dimensional. It takes less time but we found it harder for a drug worker to interpret than EuropASI.

Both have their strengths, but for us they did not fit the bill. We are an open access service offering a range of interventions and operating to a three-day local standard for seeing new referrals. Over the five years we looked at these tools

Complex tools fail to deliver what is urgently needed – a quick and easy method

our client numbers doubled; last year new referrals were up by 43%. Staff increases have not kept pace with increased workload. We needed an efficient means to codify and standardise our assessment data, but the comprehensiveness of these tools was also their weakness: they take too long, their structure prevents clients unfolding how they see their problems at their own pace, and they can seem intrusive for an initial contact.

In response we started using **CISS** in September 1999. CISS is a simple, one page questionnaire which can deliver a single score. By February 2000 over 230 forms had been completed at initial assessment. It proved easy to administer and there has been a high degree of consistency between workers completing forms for the same client. The ease with which it can be built into everyday work with clients means CISS is now used as part of our quarterly reviews. Completed forms are held centrally so that at follow up workers are not tempted to allocate an improved score.

Unlike other tools, CISS does not require the client's presence. Most street agencies and community drug teams only know a client has been 'discharged' when they lose contact. They do not have the resources to follow them up, and for many it would be inappropriate to do so. Despite this, CISS allows initial assessment, review and discharge scores to be collected.

I can understand that purists will find fault with the simplicity of CISS, but that is its attraction for hard pressed staff. Outcome monitoring is essential, but until services have their own researchers or statistical support, the more complex measurement tools will fail to deliver what is urgently needed – a quick and easy method to indicate the initial severity of the problem and any subsequent changes. In the end what is important is to be able to demonstrate that there has been improvement since first contact.

Now CISS has been validated, any agency looking for an effective and efficient means of codifying client information should consider adopting it.

Paul Wells

Team Leader, Coventry Community Drug Team, phone 01203 553845.

1 Ashton M. "NTORS." *Drug and Alcohol Findings*: 1999, 2, p. 16–22.
2 Gordon-Smith J, Christo G. "Are we right to spend more?." *Drug and Alcohol Findings*: 1999, 1, p. 26–27.

The toolmakers reply

CISS It is gratifying that Paul Wells has clearly identified CISS's purpose – a tool for those of us who work in busy services with no researchers and limited administrative support, where overworked staff have no time for forms, or already have tried and tested qualitative assessment interviews. It is for clients who may be uncooperative and stressful to work with, have reading difficulties, fail to turn up for assessments, discharge themselves without discharge interviews, or have their own agendas of things they want to tell you about.

In June 1999 FINDINGS was the first magazine to feature CISS. Since then the CISS validation study has passed peer review and will shortly be published in the international journal *Drug and Alcohol Dependence*.[1] CISS has also been featured in *Addiction Today* and *Druglink* and has rapidly grown in popularity; I have had about 200 requests for copies from across the UK.

The "purists" Paul refers to may be reassured that the pedigree of CISS is more than adequate. Its author has worked in this field for 15 years and holds doctorates in substance misuse treatment outcomes research and in clinical practice. The validation study basically showed that CISS is comprehensive, accurately measures what it is supposed to measure, and that different workers rating the same client will produce similar results – essential features of a useful instrument.[2]

If any other services want to try CISS, I will happily send them a copy with comparison scores.

George Christo

Royal Free Drug Service, 457 Finchley Road, London NW3 6HN, phone 020 7431 1731, e-mail DrGeorgeChristo@breathemail.net. CISS web site http://users.breathemail.net/drgeorgechristo/

1 Christo G, *et al*. "Validation of the Christo inventory for substance-misuse services (CISS): a simple outcome evaluation tool." *Drug and Alcohol Dependence*: in press, May 2000.
2 CISS's alpha internal consistency was 0.74; test-retest reliability 0.82; inter-rater reliability 0.82 and 0.91; discriminant validity 88% at a cut-off score of 6. Convergent validity is demonstrated by correlations of 0.43 to 0.99 with the Opiate Treatment Index and measures of trait anxiety, unpleasant life events, poor quality of life and low self-esteem.

LINKS
Issue 1, p. 26–27. CISS in practice.
Issue 1, p. 25–26. What commissioners want to know.
This issue, p. 21–23. Client follow-up at two alcohol services.
To come. MAP theory and practice.

MAP Outcome monitoring is hard work and requires a sustained commitment to gathering information – no one said it was going to be easy. That's why there are so few working systems across the world. Nevertheless, we're seeing a great surge of confidence in the UK about measuring outcomes on a day to day basis in treatment centres, and it's important for Paul and his staff team to have found a method which works for them and which they can use routinely.

As a researcher I make decisions about which questionnaires to use all the time, and use different ones for different purposes. Obviously, I think MAP is a good choice for treatment providers to make for outcome monitoring since we designed it with this in mind.

MAP records the core set of indicators used in outcome studies in our field, in a form everyone can readily understand and which can feed directly into the reporting of progress towards meeting the targets and goals of the UK's anti-drug strategy. It takes just 12 minutes to complete and was designed as a personal interview (although this could be over the phone), but self-completion by the client is an option we've tested and it works well.

I appreciate that busy centres will gravitate towards the least onerous way of collecting outcome information (ie, a proxy assessment from case notes) but I am not convinced that drug action teams and service commissioners will happily accept non-standard reporting. They want to know

Commissioners want to know concrete things – like 'How many fewer crimes were there?'

concrete things – like 'How many fewer crimes were committed by the clients?' Can Paul's service tell them that?

The real challenge is how to ensure that valid and reliable measurement of outcomes is a sustainable part of an agency's work and culture. That's why the new DAT-led schemes which enable services to feed in their forms for analysis are such an exciting development.

John Marsden

National Addiction Centre. For more on MAP visit http://www.ntors.org.uk/ntors.html or e-mail J.Marsden@iop.kcl.ac.uk.

Tackling alcohol together.
The evidence base for a UK alcohol policy

Edited by Duncan Raistrick, Ray Hodgson, Bruce Ritson. London: Free Association Books, 1999. 350pp. £15.95 pbk.

A basis for British alcohol policy – or an unoriginal mish-mash?

You know how it is. You're in the audience at an international conference on alcohol problems listening to the opening session. The first speaker is a Scandinavian who probably is saying something important but is rather difficult to follow, particularly as he uses no visual aids. The second is a globetrotting superstar who gives a flash *Powerpoint* show with loads of graphs and much too much data to assimilate at a single sitting. And the third, presenting the British perspective, uses old fashioned, rather shabby overheads. He starts by repeating data already delivered by the other speakers, trying for a domestic spin by talking about a little local study, allegedly the result of attempting to stand on those previously presenting giants' shoulders. If those three presentations were books, they would be Kettil Bruun's *Alcohol Control Policies in Public Health Perspective*,[1] Griffith Edwards's *Alcohol Policy and the Public Good*[2] – and *Tackling Alcohol Together*.

It's not that this new one, *Tackling Alcohol Together*, is not a worthwhile book. It is well written, comprehensively documented and flows remarkably smoothly for a multi-author book. The problem is that it is totally lacking in creativity or originality. Indeed, its format and arguments so closely follow *Alcohol Policy and the Public Good* that one can feel the vital fluids of that book seeping through its veins.

It consists of 13 chapters and three appendices. The chapters are in four sections, all very predictable: "Setting the Scene" – history and stuff about policy being everybody's business; "Patterns of Drinking and Associated Risks" – drinking in different populations, intoxication in social and environmental contexts, individual and population level risks; "Influences on Drinking and Related Problems" – price, regulation, media, generalist and specialist treatment and training; and "A Systems Approach to Policy", derived from the work of Harold Holder in the USA. The first appendix is interesting, listing key documents in the development of alcohol policy in Britain between 1959 and 1998 (though it is headed "1950 to 1998"). The second reports the findings from a clearly flawed point prevalence postal questionnaire survey of alcohol clients attending British treatment agencies on 4 December 1996.

Despite its claims to be "The evidence base for a UK alcohol policy", the book is a mish-mash of evidence from all over the place, interspersed with pleas and polemic. It bleats away about how much we spend on alcohol, and about how many of us still drink over the so-called safe limits; about how people use alcohol to get drunk (what else is it for?); about how much misery and mayhem our drinking causes. And it makes a big point about ambivalence – that we love drinking despite the problems it causes. Yes, in the same way as we heat our homes and cause global warming; drive our cars and kill people on the roads; buy cheaper food from supermarkets and fund battery farming. Now, what is the point the authors are trying to make?

And yet ... there are important issues and agendas here. Our drinking does cause harms, and some of these could be and should be minimised. But let us not forget that one of society's principal tricks to deal with the aforesaid ambivalence was to create a deviant minority of drinkers upon whom we could lumber our stigma. Only when we stop doing that will we be able to tackle alcohol problems seriously. We have to start by deconstructing alcohol dependence or alcoholism or dipsomania or problem drinking or whatever you care to call 'it'. Then, but not until then, can we start *Tackling Alcohol Together*. You know how it is.

Douglas Cameron
Senior Lecturer (Clinical) in Substance Misuse
University of Leicester

1 Bruun K., *et al*. *Alcohol control policies in public health perspective*. Helsinki: Forssa, 1975.
2 Edwards G., *et al*. *Alcohol policy and the public good*. Oxford University Press, 1994.

SOURCE

Tackling Alcohol Together is available from Alcohol Concern, phone 020 7928 7377, price £15.95 plus 10% p&p.

The editors of Tackling Alcohol Together reply

Douglas Cameron seems to have missed the main objective of this book. The forthcoming National Alcohol Policy is expected to be the most important UK alcohol policy statement since the Kessel Report. *Tackling Alcohol Together*'s sole purpose is to inform both those involved in drafting the policy and any subsequent consultation or debate, complementing a more consultative project conducted by Alcohol Concern. The key elements of the national policy will be determined by policy makers and service commissioners and they are the book's primary targets. It follows that we would wish the book to be judged on how well the complexities of drink and drinking are summarised for the non-specialist rather than for academics or for the international conference circuit.

It is true that the book follows the approach of *Alcohol Policy and the Public Good*; we consider this to be a strength. In the case of *Tackling Alcohol Together*, the Society for the Study of Addiction invited a group of distinguished scientists to prepare position papers on their specialist subjects. These were debated and then edited to be pooled into an integrated text. *Tackling Alcohol Together* attempts to bring together evidence pertinent to the UK. Of course, much of this originates from outside the UK. We believe the readership will readily understand the limitations of the evidence presented.

Douglas Cameron's preoccupation seems to lie in "deconstructing alcohol dependence or alcoholism". In fact, the book finds sympathy with this view, but only so far as the evidence takes it. If he is suggesting that differences between drinkers, such as dependence or neuroadaptive change, are unreal or are social constructs, then we strongly disagree; if he is not, then surely "deconstruction" is simply a relabelling exercise. Are we to use the term 'drink seekers' instead?

Duncan Raistrick
Leeds Addiction Unit

Ray Hodgson
Cardiff Addiction Research Unit

Bruce Ritson
Royal Edinburgh Hospital

GLOSSARY

Technical terms relating to evaluation

Standard definitions may have been adapted to fit the context of evaluations of interventions in the drug and alcohol fields. Terms defined elsewhere are italicised.

Attribution A judgement on whether one event was actually caused by another or whether another explanation can account for the relationship between the two. Usually whether an *impact* was caused by an intervention. Will depend on whether alternative explanations can be eliminated and whether the intervention can credibly be seen as the cause.

Attrition The degree to which a study fails to include all the intended subjects due to factors such as drop-out or inability to contact them. Can occur at various stages from initial recruitment into the study to follow up. May threaten the comparability of *treatment* and *control groups* and how far these remain representative of the intervention's *target group*.

Blinding See *double-blind*.

Comparison group See *control group*.

Control group A group of people ('controls'), households, communities or other *units of analysis* who do not participate in the intervention being evaluated. Instead, they usually receive an alternative intervention (in which case the term *comparison group* may be preferable) or no intervention at all. Observations made on the controls are used to decide whether the intervention had an *impact* on the *treatment group*(s) and whether this was *statistically significant*.

Cost-effectiveness One intervention is more cost-effective than another if it achieves more of a desired *outcome* for a given expenditure.

Cost-benefit NEW In a cost-benefit analysis both the costs and the benefits of interventions are expressed in monetary terms. This enables us to assess whether an intervention gained more than it cost and whether an alternative intervention achieved greater benefits for each £ spent.

Double-blind Research designs in which neither the subjects nor those taking measures from them know which intervention (if any) the subject received. Eliminates bias due to expectations or preconceived views. For the same reason, researchers may also be 'blinded' to other variables, such as characteristics thought to make subjects more or less receptive to interventions. See *placebo*.

Drop-out See *attrition*.

Effectiveness The degree to which an intervention produces the desired *outcomes* under everyday conditions typical of those in which it will usually be applied. Contrast with *efficacy*.

Efficacy UPDATED The degree to which an intervention produces a desired *outcome* under relatively optimal or ideal conditions such as with expert, well trained staff, and selected subjects. A measure of its potential benefits rather than what we can expect from it in normal conditions. Contrast with *effectiveness*.

Evaluation UPDATED The systematic attempt to assess an intervention in terms either of its feasibility or whether or how it contributes to desired *outcomes* or other *impacts*. Colloquially, whether and how it was implemented, and whether and how it worked.

Experimental group See *treatment group*.

External validity The degree to which what is evaluated in a study (and the conditions under which it is evaluated) permit us to assume that similar *impacts* will be observed in everyday practice. Can be maximised either by limiting the claims made for the study's *generalisability* or by employing more *naturalistic* research designs. Contrast with *internal validity*.

Generalisability How far an evaluation's findings will be replicated in similar situations not actually studied. Normally the main issue is whether the results will apply outside the research context to everyday conditions.

Hypothesis A formal prediction about what will happen as a result of an intervention. Such predictions are tested by the *evaluation*.

Impacts All the consequences of an intervention including intended and unintended *impacts* on the *target group* and more broadly.

Inputs NEW The resources used to deliver an intervention, whether human, financial or physical.

Instrument UPDATED An organised method for consistently collecting information such as questionnaires, guidelines for conducting interviews and making observations, and protocols for testing urine and saliva. Because evaluations depend critically on how well they measure *outcomes* and other variables, instruments should be *objective*, *reliable* and *valid*.

Internal validity The extent to which the research design enables us to decide whether the intervention caused the observed *impacts*. The controls needed to achieve high internal validity often distance a study from real-world conditions, threatening its *external validity*. Internally valid studies are usually best suited to demonstrating *efficacy*. Contrast with *external validity*.

Longitudinal Research designs which aim to assess and reassess the same subjects at several time periods. For evaluations, the benefit of such designs is that they permit changes in each subject to be assessed against earlier measures taken from the same subject. See *prospective*.

Mediating (or intermediate) **variables** UPDATED Variables affected by the intervention which help cause the anticipated *outcomes*. For example, ability to refuse drug offers is increased by some prevention programmes and in turn is thought to lead to reduced drug use. When *outcomes* are hard to measure, changes in mediating variables may be used as a proxy for assessing the intervention.

Meta-analysis A study which uses recognised procedures to amalgamate results from several studies of the same or similar interventions to arrive at composite *outcome* scores. Usually undertaken to enable *effectiveness* to be assessed with greater confidence than it could have been on the basis of each individual study.

Milestones Key stages in the intervention process which underpin later *outcomes* and which can be documented and monitored. For example, in treatment may be numbers attending for assessment or retained for a set period; in prevention, the proportion of the target group reached and how many then engaged with the intervention.

Naturalistic UPDATED Describes a study of an intervention in 'real-world' conditions with minimal research interference, eg, without specially selecting subjects or controlling the quality of the intervention. Most appropriate to *effectiveness* trials. Often the only feasible approach in the light of resource constraints and ethical considerations which preclude allocating subjects to potentially inappropriate interventions or to none at all.

Null hypothesis The assumption tested by *statistical* procedures that a set of observations occurred purely by chance. In the current context, the null hypothesis usually amounts to the assertion that an intervention produced no *outcomes* or that there was no difference in the *outcomes* produced by two or more interventions.

Objectivity With respect to an *instrument*, the degree to which different people applying or scoring it in the same circumstances on the same subjects would register similar values. An aspect of *reliability*.

Outcome evaluation An *evaluation* (or the element of an *evaluation*) which systematically records whether and to what degree the intended *outcomes* of the intervention were achieved. Colloquially, whether the intervention 'worked'. Contrast with *process evaluation*.

Outcomes The intended end product of the intervention or service, eg, changes in substance use or problems, infection control, reduced crime. To be distinguished from changes in *mediating variables* and *outputs*.

Outputs Records or indicators of the level of throughput or activity of a service such as counselling sessions provided, level of occupancy of a residential service, training sessions provided and attended. To be distinguished from *outcomes*.

Placebo A dummy intervention which mimics but lacks the presumed active ingredient of the intervention. Used to prevent subjects' expectations or preconceptions of the intervention systematically biasing *outcomes*. It is often impossible to construct a placebo condition when testing psychosocial interventions. See *double blind*.

Process evaluation An *evaluation* (or the element of an *evaluation*) which systematically documents the planning, implementation and delivery of an intervention. This may be as part of an attempt to establish its practicality (a feasibility study) or to elucidate how and why any observed *impacts* may have occurred. Colloquially, *how* the intervention 'worked' or why it did not. Contrast with *outcome evaluation*.

Prospective A study in which the subjects are recruited (and normally baseline measures taken) before the intervention takes place. Advantages usually include enabling *attrition* to be accounted for and *impacts* to be assessed by comparing measures taken after the intervention with those taken before.

Randomised controlled trial A study in which subjects are allocated at random to different interventions and/or to intervention and *control* groups. The intention is to eliminate the possibility that any *impacts* arose due to differences between the subjects in these groups rather than the intervention. Such studies are rare and (since self-selection or referral to interventions are the rule in practice settings) may suffer from low *external validity*.

Reliability A highly reliable *instrument* will deliver near identical results in repeated data collections with the same subjects tested under the same conditions, and will do so even when different people administer and score the test. An *instrument* is unreliable to the degree to which measures taken with it may vary even when what it is supposed to be measuring has stayed the same.

Spontaneous remission Also termed 'regression to the mean'. The tendency for relatively extreme or unusual behaviour (or attitudes, etc) to revert to more usual levels without formal intervention. Particularly relevant to therapeutic interventions as people often seek help when their problems have become unusually severe.

Statistical significance UPDATED The findings of a study are accepted as statistically significant when they are very unlikely to have occurred by chance. The cut-off point is set by convention, normally at less then 1 in 20, expressed as a probability of less than 0.05 or '$p<0.05$'. If lower probabilities emerge we assume that something other than chance caused the results. A well-designed study enables us to decide whether or not this 'something' was the intervention.

Statistical tests Accepted arithmetical methods to determine the probability that a set of observations (measures, scores, categories, ranks) occurred by chance. When this probability is below a certain level the observations are accepted as *statistically significant*. Such tests are important as extraneous causes of variation in *outcomes* could lead to unjustified conclusions about how well an intervention worked.

Target group The people, households, organisations, communities or other identifiable entities which an intervention is intended to affect. The degree to which the intended changes occur in this group constitute the *outcomes* of the intervention. However, *impacts* may also be seen in non-targeted groups.

Treatment group People, households, organisations, communities or any other identifiable entities which receive an intervention as opposed to the *control group*. The term 'treatment' does not imply a medical or therapeutic intervention and may be replaced by 'experimental' or 'intervention'. Contrast with *control group*.

Unit of analysis What constitutes a 'case' or 'subject' in the study. Usually an individual, but may be a group, a service, a family, a class or a school. To avoid mistaken *statistical* conclusions, the units *randomised* to *treatment* and *control* groups should correspond to those used to measure *outcomes*.

Validity With respect to an *instrument*, the degree to which it measures or otherwise reflects what it is supposed to measure. For example, whether the results of a questionnaire intended to measure drug use correspond to accepted or more direct indicators of drug use, such as a pre-validated *instrument* or urinalysis results. With respect to an *evaluation*, the degree to which conclusions drawn from the data correspond to reality. See *internal validity* and *external validity*.

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