DRUG & ALCOHOL FINDINGS

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Are we right to spend *more*?

Commissioners in west London were riding their hunches when they extended care regimes. They needed to check the results, but quickly, cheaply, and with the emphasis on practicality. In the process they tested a new assessment tool whose simplicity encourages routine use. Evaluated and evaluator tell the story.

EVALUATED

Hunches are not enough

by **John Gordon-Smith**
Manager, Alcohol and Drugs Team, Hammersmith and Fulham Social Services.

In 1993 social services in England and Wales became responsible for funding community care, including the rehabilitation of drug and alcohol users through residential or intensive day care services. This care is expensive, but only rarely do purchasers systematically investigate how to make the most of their investment. Hammersmith and Fulham's placements are jointly purchased by the health and local authorities, which agreed to split the costs of just such an evaluation.

Since they would have to complete the evaluation forms, the commitment and co-operation of social workers in the Drugs and Alcohol Team was vital. They met the researcher in advance, were fully aware of the objectives, and involved in the planning. Their interest was stimulated by the chance to test their own hunches and observations.

They reasoned that good progress in treatment should be consolidated by extending it, both directly and through aftercare, since relapse seemed most common immediately after treatment exit. In line with this view the team had become involved in organising aftercare, including a weekly drop-in, a weekly social club run by and for ex-drug users, contacts with counselling agencies, and a local hostel. They risked being seen as diverting limited resources from the core tasks of assessment and care management. Also, extending treatment and funding aftercare absorbs costs which could otherwise be used to fund more placements. Set against this was the possibility that aftercare may actually reduce costs by reducing the demand for later re-admission. What did the data show?

Some hunches validated

In some respects the team's approach was supported by the research. Apart from compliance issues (turning up on time, etc), at six months, when most clients had left their initial treatment, continued use of structured support was the factor most strongly linked to good outcomes. At the very least these findings are consistent with an emphasis on aftercare and on motivating and helping clients to comply with assessment and treatment. It seems particularly important to maximise treatment completion; in this research premature leavers had less than a 1 in 20 chance of a good outcome at six months.

The study also enabled us to assess certain aspects of social services' role in assessing and placing clients. The average six-week delay between assessment and placement may not seem ideal, but is often needed for the client to prepare for rehabilitation, such as by completing a detox. It is also reassuring that longer delays were not associated with poorer outcomes. Delays were at least partly associated with poor compliance on the part of the client. This does not absolve social services of responsibility, but does redirect attention to tactics (reminder letters, phone calls, etc) to improve compliance. Again, it was reassuring to see that clients already in treatment or in contact with the health authority's central assessment unit had better outcomes, suggesting these services were fulfilling their preparatory roles.

Over half of all placed clients completed treatment and 80% of these were doing well at six months. The results are consistent with our view that assessment is a valuable way to ensure clients understand the different treatment philosophies, how the funded programme meets their needs, and in judging how committed they are to treatment.

Where the evaluation does raise questions is over the need for lengthy residential treatment: *completing* treatment seemed more important than how long the programme was, raising the possibility that programmes designed to be short may work better by making it easier for clients to complete. Given the severity of many clients' problems, there must, however, be a limit to how quickly these can be turned around.

Making it routine

Like the businessman who bought the company, we were impressed enough by the evaluation to incorporate its methodology in our day-to-day work – a testament also to the ease with which this could be done. We now complete the forms at assessment, six weeks, six months and a year, and hope to find ways of including clients who drop out of treatment. Our involvement in the research has been a positive experience, one that provoked debate about service delivery and the wider issue of commissioning and purchasing the most effective treatment options.

EVALUATOR

Keep it simple

by **George Christo**

Doctor in substance misuse treatment outcome research and clinical psychology. Currently engaged in freelance research and teaching and practises clinical psychology at the Royal Free Drug Service. This study was conducted from the Centre for Research on Drugs and Health Behaviour.

Evaluating Hammersmith and Fulham's drug and alcohol service placements required a way to measure outcomes which did not need researchers to interview clients and which drew on routinely collected information rather than demanding yet more be collected.

Ideally the instrument would measure the usual areas: drug/alcohol use, social functioning, health, HIV risk behaviour, psychological well being, occupational status, and crime. It would have to be reliably completed by busy social workers without extended coaching, so would have to be convenient, short, and compatible with current procedures. To make it easier to understand and analyse, a single score representing the client's status should easily be computed.

A process which required the client's presence at a set time would suffer unacceptable completion rates. Clients at rehabilitation houses are often difficult to contact; others may not turn up just to complete a questionnaire. However, social service teams often already have a wealth of qualitative data from assessment interviews and client notes. We needed some way to transform these into *quantitative* data enabling the progress of one client to be compared with another.

This strategy was pragmatic rather than ideal. Clients *are* more likely to give valid answers in confidential interviews with researchers not seen as part of the treatment system, when nothing is to be gained by misrepresentation. However, where such researchers are not available, on the face of it information given routinely to key workers is as likely to be valid as that given to the same workers through special questionnaires.

Developing the inventory

No existing questionnaire fit this bill. Typically they took too long, required the presence of the client, and sub-sections could not be combined produce a single score for easy analysis. Something new had to be developed. This became the *Christo Inventory for Substance Misuse Services* (CISS).

It was designed to elicit workers' impressions of their clients in a quick, standard and reliable way. Outcome areas are scored on a three-point scale of problem severity, each illustrated with examples. As well as the seven usual variables, research indicated that three further variables relating to the interaction between client and service had a major effect on outcomes: ongoing support (eg, counselling, support groups, AA or NA); treatment compliance; and the worker–client relationship. Including these meant the CISS assesses outcomes on 10 dimensions with a total score ranging from 0 to 20.

The Hammersmith and Fulham evaluation was used to test the CISS's usefulness, sensitivity to change in clients, and ease of completion. Its success has led to its incorporation in routine procedures. A validation study under peer review has produced good results for reliability and internal consistency and acceptable correlations with standard questionnaires. This study will be formally published, opening it to scientific scrutiny.

The CISS is now being used for evaluation of both abstinence-based and prescribing services for drug users, where it has been possible to establish standard score ranges indicative of good v. poor outcomes and low/average/high problem severity. Comparison scores are also available for alcohol users. Such standards enable other practitioners to compare their clients with a 'typical' group.

Pros and cons

Most of the plusses of the CISS relate to its usability in routine practice. Its single page is easy to photocopy, and can be completed in three minutes face-to-face or from client notes. It is suitable for abstinence-based or prescribing services and is intended for drug or alcohol users. The single score it produces can be used at intake to ensure that staff carry caseloads of roughly equal difficulty and then to monitor client progress. Unusually, it tracks important dimensions of the client's relationship with the service, highlighting problems which may impede client progress and may indicate the need to adapt the service to improve the relationship.

However, the CISS is primarily an evaluation tool and may not be suitable for research requiring measures of different outcome dimensions. Its scales measuring such dimensions are not very sensitive to change; sensitivity is gained only when the 10 dimensions are combined. The CISS is new and not yet as proven as other instruments, and has yet to be complete peer review.

Results from the CISS can only be as good as the information recorded in routine assessment and monitoring. Information from these should be sufficient for a competent worker to produce an acceptably accurate record of their client's status. Gaps would need to be filled by interviewing the client, indicating that assessment procedures are not as full they should be.

To a greater degree than some other instruments, the CISS relies on the competence and judgement of the worker administering it. Ideally, occasional cross-checks of the worker's scoring would be made using other workers and other instruments. Such checks could be integrated into routine performance monitoring as, arguably, workers unable to validly complete the CISS are also worryingly unaware of what is happening with their clients.

The study Subjects were 82 clients assessed by two social workers. 45 were placed in residential or day care after an average six-week delay. A specially developed inventory completed by the social workers was used to assess client progress at baseline and then at two and six months.

The 32 still in contact at six months (by which time all but a few had left their initial treatments) generally evidenced improved functioning. 20 of the 45 placed clients were judged to have had good outcomes, all but one after having completed treatment. Treatment failures were almost exclusively associated with leaving treatment before completion. At six months, lower drug and alcohol use was strongly associated with continuing formal support and with having already been in contact with substance misuse services at assessment.

In context Being quick without being unacceptably dirty was the priority in this feasibility study. Low follow-up rates and the lack of a control group preclude strong conclusions about the impact of the treatments. With anonymity not an issue, a more meaningful outcome measure might have been computed by pooling each individual's change over time. The results are vulnerable to wishful thinking by workers and positive (or negative) glosses by clients. Nevertheless, practice-relevant data was collected and it is easy to see how (resources permitting) cross-checks and intensified follow-up could improve confidence.

Its conclusions about the importance of treatment completion have been echoed in US research (▶ *Links*). The intuitively plausible suggestion is that it is what the client and service *do* with their time together that counts rather than the time itself.

The assessment instrument's simplicity is its strength but a single score cannot capture the fact that many clients do well in some areas but not in others. Other instruments used in a treatment context include the Maudsley Addiction Profile developed for NTORS and the Opiate Treatment Index (▶ *Secondary sources*).

Practice implications ▶ Main text.

Main sources Christo G. *Outcomes of residential care placements for people with drug and alcohol problems: an evaluation of Hammersmith & Fulham Social Services.* 1998. Copies: apply John Gordon-Smith ▶ *Contacts.*

Christo Inventory for Substance Misuse Services. Copies: free from George Christo ▶ *Contacts.*

Secondary sources For alternative assessment/evaluation instruments, see ❶ Marsden J., Gossop M., Stewart D., *et al.* "The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome." *Addiction*: 1998, 93 (12), p. 1857–1868. Copies: apply ISDD ❷ Macleod J., Scott R., Elliot L. *et al.* "The routine use of the Opiate Treatment Index in a clinical setting." *Int. Journal of Drug Policy*: 1996, 7 (2), p. 130–132. Copies: apply ISDD.

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LINKS In this issue, *Nuggets* **1.3** (p. 9) and **1.6** (p. 11).