



DRNS meeting 2019: closing remarks

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Some observations from today

DRNS goal:

Develop collaborative research across disciplines, organisations and countries to **generate** high-quality evidence that will **(and) inform** developments in policy and practice

Some observations from today

Clear focus on operationalising DRNS goals:

- Generate new knowledge:
 - Leveraged research funds. (In 2 years: 22 new grant applications, 6 funded projects worth £2.5m [~NDARC])
 - Central role of people with lived and living experience [presence here is notable]
 - Focus on identifying and being willing to tackle practical, structural problems. e.g. Magdalena H: safer injecting; better hospital care
 - Scotland risk factors cf. international e.g. Adam W

Some observations from today

Clear examples of DRNS goal being operationalised:

- Inform policy and practice:
 - Knowledge exchange focus (e.g. today)
 - Understanding client needs:
 - Roy R: multiple co-occurring health problems are typical.
 - Parallel sessions: strong engagement with ‘end users’ to understand issues
 - Recognising the value of treatment / harm reduction:
 - Roy R: being out of treatment is a mortality risk factors
 - Fiona M: increasing acceptance of onsite drug checking

Challenges - opportunities for DRNS.2 ?

- Roy R: need to at least consider radical change?
 - Legalisation; safe injecting rooms; squeezed and inadequate funding.
- Parallel sessions: lack of evidence about ‘what works’
- Reflect on the DRNS model?
 - DRNS strategic goal is a translational model – generate evidence to inform policy/practice
 - But when do we have enough evidence to introduce a new intervention? (Fiona M)

Opportunities for DRNS.2

- Not clear that translation this works very well:
 - ~14% of research translated, over ~17 years
 - John Ioannidis, Stanford

Why Most Clinical Research Is Not Useful (PLoS Medicine)

<https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002049>

- Researchers don't ask the most useful clinical questions (*'studies should be useful regardless of their results'*)
- Limited real-world context
- Patient centred, feasible, value for money...
- Most published research findings are false

Opportunities for DRNS.2

How much descriptive research do we need before we act?

Indigenous D&A research (Clifford & Shakeshaft, Drug and Alcohol Review, 2017)

Country	Years	N studies	Measures %	Descriptive %	Evaluation %
United States	1993-2000	40	0	87	13
	2008-2014	163	1	91	8
Australia	1993-2000	36	0	81	19
	2008-2014	134	6	81	13
New Zealand	1993-2000	4	0	75	25
	2008-2014	41	3	87	10
Canada	1993-2000	6	0	83	17
	2008-2014	59	0	93	7
Total		656	3	86	11

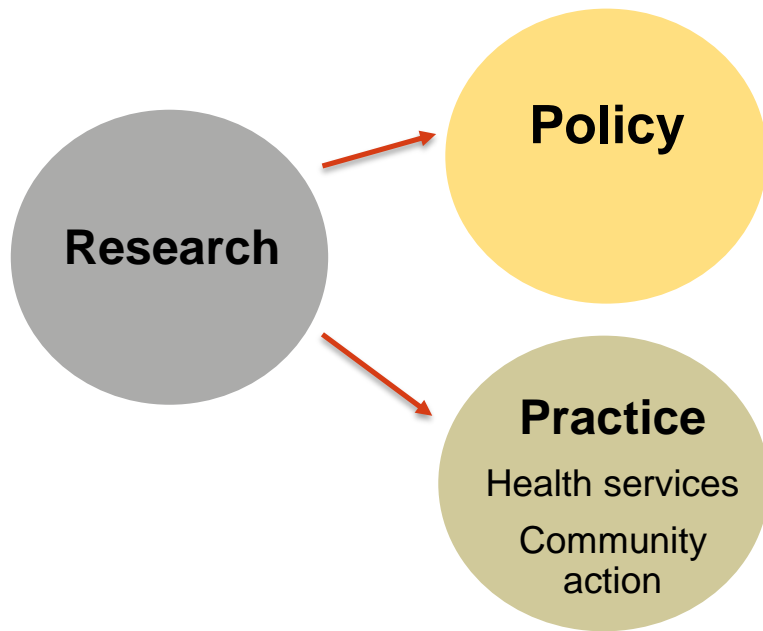
Opportunities for DRNS.2

- Alternative to translational model is an integrated model
- Less 'one-off' or 'stop-start' research
- Pragmatic research (Roy R)
- Set-up the infrastructure to do research/evaluation continually (***action research projects – Fiona M***)

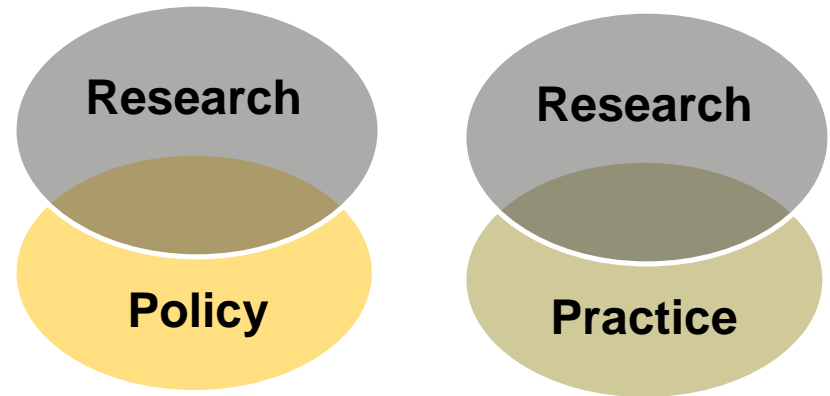
create service delivery systems that learn

From translation to integration

Translation



Integration

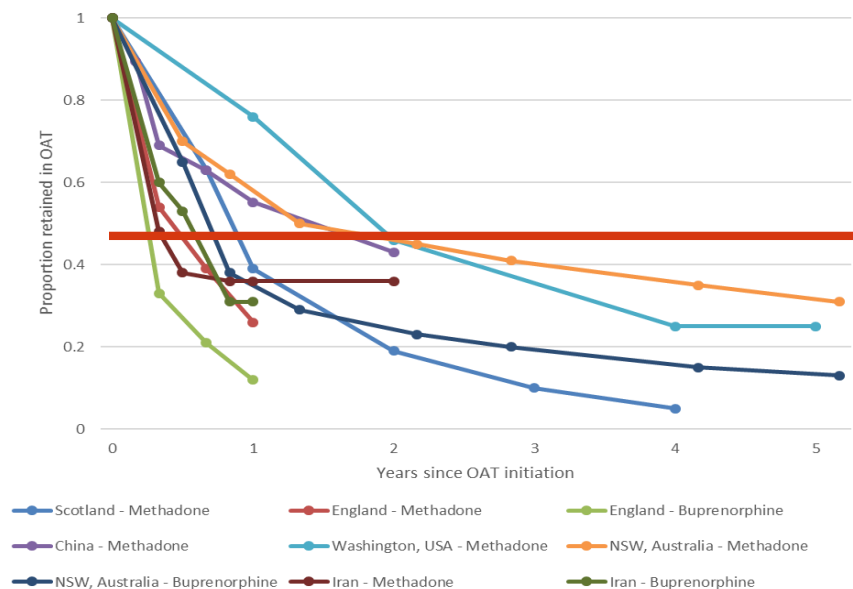


Features of integrated research

- Pragmatic trials / learning systems
- Research quality administrative data
- Co-design of interventions
- Co-design organisational change process

Example 1: OAT provision

- Thanks to Louisa Degenhardt and colleagues...
- Some things we know about OAT (in Scotland)
 - Highly skewed retention
 - Methadone > buprenorphine



Example 1: OAT provision

- What might impact on retention?
 - Sub-optimal dosing
 - Limited access to unsupervised dosing
 - Urine drug screening
- Talk to clinicians, consumers and pick an issue with high consensus about the problem/solution (e.g. dosing regimes)
- Evaluation - randomised trial possible?:
 - Standard randomisation / adaptive trials / client choice

Example 2: Systems of care

- Some things we know about systems of care
 - Local health authorities fund different services?
 - Substantial % of D&A clients have multiple, co-occurring risk factors (MH, housing, unemployment, physical health, etc)
 - Creates 'unhelpful' competition between service providers
- Is patient-centred, 'joined-up' care a good idea?
 - All clinically guidelines (internationally) say yes
 - Systematic reviews are positive about effectiveness of integrated care
 - There is no evidence at all about how to efficiently transition from separate to integrated D&A and MH care (Cath Foley –

Example 2: Systems of care

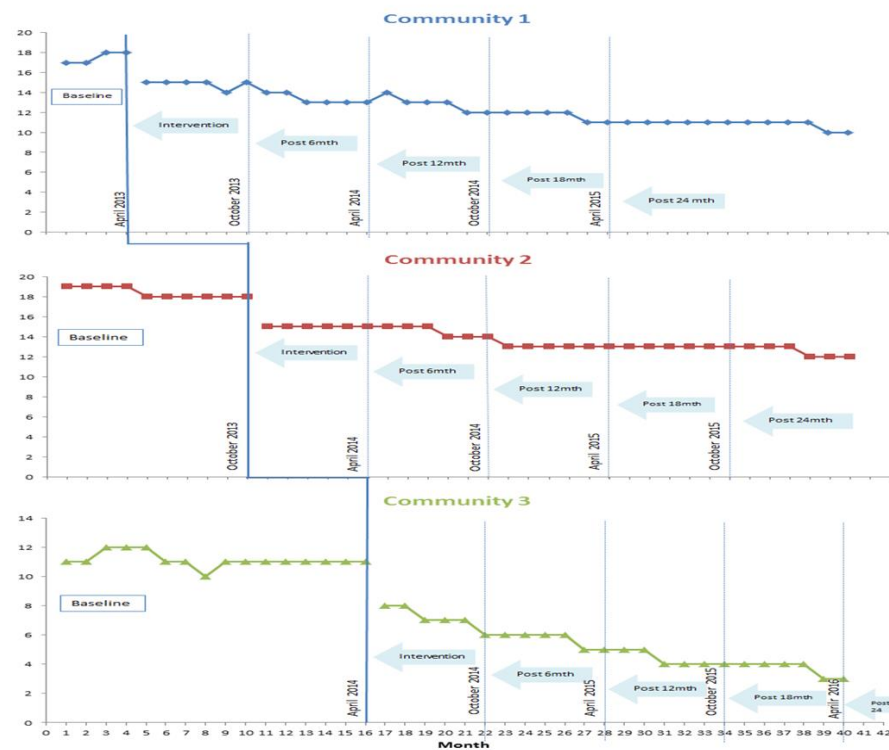
- Core components of a system of care
 - Availability of a range of services: D&A, MH, housing, employment support, skills training, building relationships, pregnancy/neonatal support
 - Public health lens: early identification and prevention (e.g. in pregnancy) → specialist clinical services (including MAP, HAT)
 - How do we organise the system to provide the right service at the right time

Example 2: Systems of care

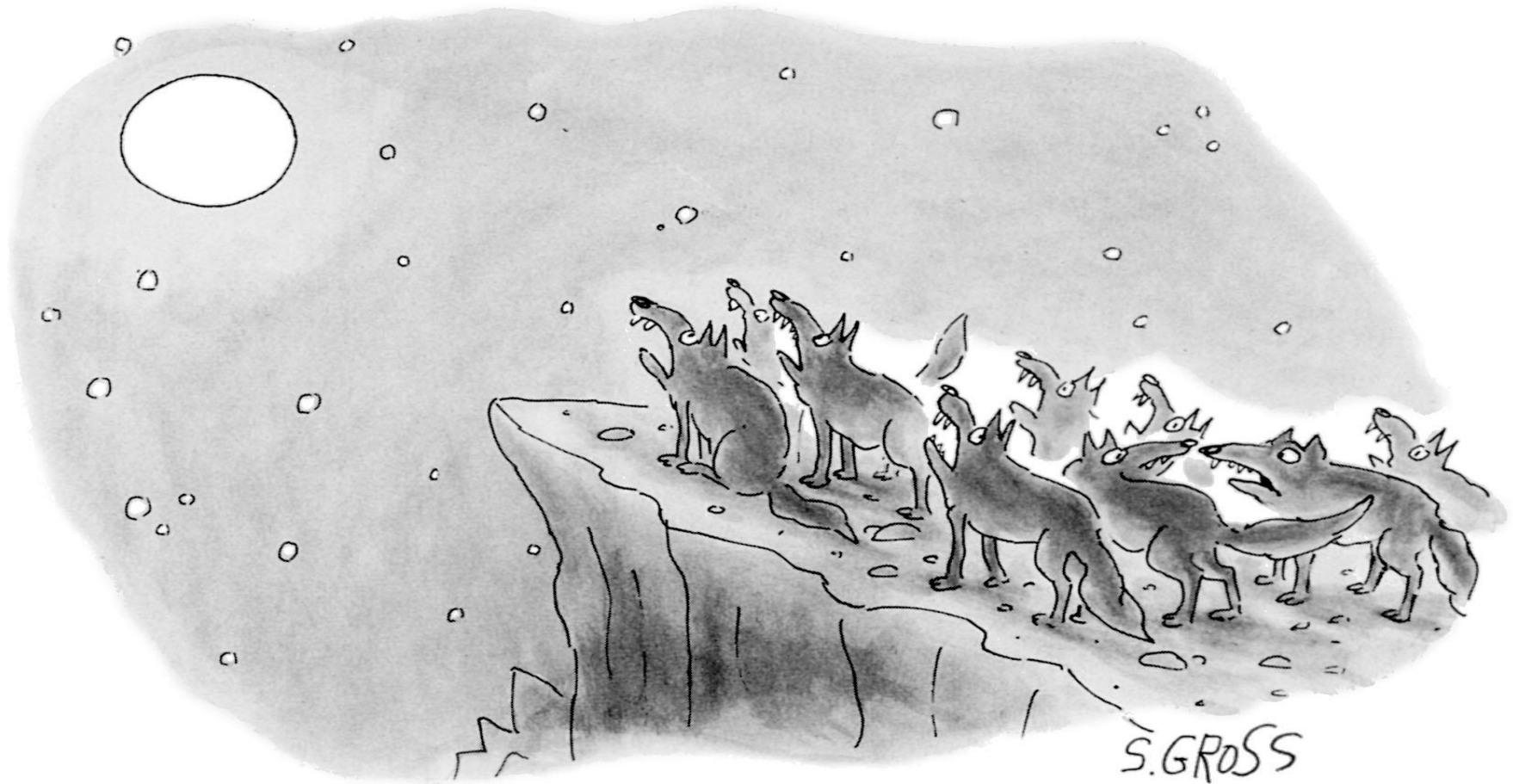
- Possible primary outcomes from a system of care
 - Client wellness / QoL
 - PREMS / PROMS
 - An “issue’ specific measure (e.g. TOP for D&A)
 - Administrative data-sets:
 - ED presentations
 - Health services utilisation
 - Linked data across homelessness, health services, etc
[Parallel sessions – using linked data is hard so set up linked data infrastructure, not one-off projects??]
 - Need to demonstrate the value of this and that ethics/privacy concerns can be managed

Example 2: Systems of care

- Evaluation - randomised trial unlikely (even a clustered one)
 - Stepped wedge / multiple baseline?



Summary – focus on impact...



“My question is: Are we making an impact?”