Evaluation of the Leeds Dependence Questionnaire (LDQ) for New Zealand

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EXECUTIVE SUMMARY

The aim of this research project has been to evaluate the Leeds Dependence Questionnaire (LDQ) for use in New Zealand. In essence, the central question was "How well does the LDQ measure dependence in New Zealand populations?". In summary, the answer is that the LDQ performs very well. There is strong statistical evidence that a high LDQ score actually represents a high level of dependence and a low score represents a low level of dependence. Furthermore, the LDQ performs well for each of the three ethnic populations studied and for both male and female clients. In other words, the LDQ has been validated for use with English-speaking New Zealand European/Pakeha, New Zealand Maori, and Pacific Nation clients in mainstream services.

This finding is not enough in itself, however, to ensure sustained clinical use of the LDQ. The question must also be asked, "How useful is the LDQ in a practical treatment setting?" This research project attempted to answer this question and the overall conclusion reached was positive. When used appropriately, the LDQ is likely to be of practical use in a mainstream treatment setting. The LDQ is brief and easy to understand. If used for alcohol dependence[1], with standard clinical interpretations of the scores, and in conjunction with other measures of alcohol and drug problems, the LDQ has the potential to be very useful.

Two further issues were explored in the research. The first concerned the potential sensitivity of the LDQ to change. Although this issue was not intensively studied, the range and variability of the scores obtained from the RADS study populations supported the LDQ on this count. The second issue concerned the instrument's potential value for outcome measurement. Once again, the finding was positive.

These findings have implications for the specialist alcohol and drug treatment field in New Zealand. The LDQ can now be used with confidence for preliminary client triage screening[2]; client assessment more generally and treatment goal selection; outcome measurement, both for research and for rational health purchasing; and for various other research purposes.

[1] This does not indicate that the LDQ is an inappropriate tool for use with other drugs - merely that the published evidence to date does not permit anything more than a conservative approach at this stage.

[2] The AUDIT, LDQ, and SDS are already in use at RADS for the purposes of triage screening.

THE VALUE OF MEASURING DEPENDENCE

Defining Dependence

Elements of the concept of alcohol dependence were first advanced by the World Health Organisation in the 1950s (Polich et al 1981, p.6) and in the mid-1970s the notion of an alcohol dependence *syndrome* was formally presented (Raistrick et al 1994, p.563). Since this time the notion of alcohol dependence has attracted considerable interest and debate (Edwards 1986).

These concepts have migrated across into the study of substances other than alcohol and several instruments have been produced which attempt to measure dependence across a range of substances. These include the LDQ and the Severity of Dependence Scale (SDS) (Gossop et al 1995). In addition, empirical support for the generalisation of the dependence syndrome across substances (with the exception of hallucinogens) has recently been provided (Morgenstern et al 1994).

Substance dependence can be viewed in either psychobiological terms or in a purely psychological sense. The designers of the Leeds Dependence Questionnaire have adopted a purely psychological view of dependence - at the same time, however, they have used the psychological phenomena as a way of tapping into physiological phenomena such as withdrawal and tolerance (Raistrick et al 1994, p.564).

The LDQ evaluates 10 markers of dependence: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user's day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence. These markers are all measured in such a way that the total ratings of dependence can range across a continuum from 0 to 30, where 0 represents the absence of dependence and 30 represents extreme dependence (Raistrick et al 1994, p.565).

Dependence is widely conceived of as analytically distinct from both consumption levels and the social, legal and health problems typically associated with consumption (Gossop et al 1995, pp.607-608). Although these phenomena covary at a general level, they must be disaggregated for the analysis of individuals or subgroups.

Using Measures of Dependence

Measures of dependence are useful in a variety of ways and can be used for:

- preliminary client triage screening
- client assessment and treatment goal selection (Allen & Mattson 1993)
- outcome measurement for the purposes of research and rational health purchasing (Andrews et al 1994, p.20)
- the interpretation of outcomes (Committee of the Institute of Medicine 1990, p.321) and research on alcohol and drug treatment more generally.

Preliminary Client Triage Screening

The LDQ is short enough to be useful as part of a brief screening package for triage purposes. Trials have already begun at Regional Alcohol & Drug Services to use a package comprising the AUDIT, LDQ, and Severity of Dependence Questionnaire (SDS), in combination with clinical judgement, to initially assign clients to more or less intensive treatment streams. It is expected that a full evaluation will be published later.

Selecting Treatment Goals

Objective measures of dependence can play an important role in identifying suitable treatment goals (Allen & Mattson 1993). Where alcohol is the substance used, moderate drinking or controlled drinking might be appropriate goals for low dependence clients and abstinence the most prudent goal for heavily dependent clients (See Mattick et al 1993, p.91). There are indications, for example, that the SADQ may be useful for this purpose (Stockwell et al 1983, p.147). This is not to say that LDQ scores should be used to force clients into adopting particular treatment goals (Mattick et al 1993, p.91). Even when there is a clear medical reason for adopting complete abstinence there are clinical reasons for allowing client choice. Sobriety sampling, tapering down, and trial moderation may all represent more effective strategies for attaining abstinence than enforced "cold turkey" (Miller & Page 1991). Nor is to say that a diagnosis of severe dependence precludes successful adoption of a controlled drinking pattern (Booth 1990). Dependence must be seen as one of many factors influencing treatment outcome (Moore 1993; Mattick et al 1993, p.91).

Measuring the outcomes of treatment

Standardised instruments such as the LDQ are necessary for the aggregation of outcome measures across an agency and to allow comparisons between data collected at different agencies and at different points in time. Clinical judgements are too unreliable for this task (Andrews et al 1994, p.20).

Interpreting the outcomes of different treatment programmes

Assessment information is critical to the interpretation of treatment outcomes, whether for research or health purchasing purposes. Information on the level of dependency may be particularly salient (Edwards 1986, p.179). An agency specialising in mildly dependent clients, for example, which attains a 60% success rate may be less effective than an agency which attracts heavily dependent clients but only attains a 45% success rate (Committee of the Institute of Medicine 1990, p.321). For comparisons of this sort to be made the relevant agencies must use the same assessment and outcome instruments (Howard 1993, p.667; Frawley 1991). This is where the LDQ could prove to be particularly valuable.

Determining the extent of generalisability

The pattern of client characteristics in a studied population needs to be mapped so that the bounds of generalisability can be identified. The definition of an "adequate" description of clients is always being revised as new information is discovered (Longabaugh & Lewis 1988, p.170) but it is clear that dependency levels can play an important role. The LDQ might prove useful for the purposes of describing client populations. In this report, for example, it has proved useful to be able to compare LDQ scores between the Leeds Addiction Unit and Auckland Regional Alcohol & Drug Services.

THE BENEFITS OF VALIDATING THE LDQ FOR NEW ZEALAND POPULATIONS

The Leeds Dependence Questionnaire (LDQ) has been studied in the United Kingdom and has good psychometric properties with a range of populations including students, general practice patients, and the clients of specialist alcohol and drug treatment clinics (Raistrick et al 1994). There is still a need for New Zealand research, however - not least of all to assess its properties when used with New Zealand Maori and Pacific Nations clients.
At present, there is nothing available to the field which has been validated for New Zealand Māori and Pacific populations. This research will potentially fill this gap.
Having validated the LDQ for (English-speaking) New Zealand Maori and Pacific Nation populations, it is even possible that it could be used in studies testing the validity of other tools which have yet to be tested for these populations.

RESEARCH AIMS

In their 1994 research report *Development of the Leeds Dependence Questionnaire (LDQ): a questionnaire to measure alcohol and opiate dependence in the context of a treatment evaluation package* the researchers and clinicians who designed the LDQ indicated that they would value further research on the following aspects of the LDQ:

- its validity in **different cultural settings**
- its use as an **assessment tool**
- its utility for evaluating **treatment outcome**
- its validity for measuring dependence across a **wide range of substances**
- its **sensitivity to changes** in levels of dependency over time

To answer as many of these questions as possible (within available resources) in the New Zealand context the Alcohol Advisory Council of New Zealand requested a proposal from Regional Alcohol & Drug Services for carrying out this research.
The RADS proposal examined the first two questions in detail and received scientific approval from the Health Research Council. The treatment of the remaining questions has of necessity been exploratory due to resource constraints
The aims of the research were to:

- assess the validity of the Leeds Dependence Questionnaire (LDQ) for New Zealand European, New Zealand Māori, and Pacific Nations populations
- provide preliminary information on the practicalities of using the LDQ for assessment and treatment planning
- investigate in an exploratory manner the sensitivity of the LDQ to changes over time, its utility with substances other than alcohol, and its value as part of an evaluation of treatment outcome

MAIN FINDINGS

The LDQ is Valid for the Main New Zealand Populations

Introduction

A measurement is valid to the extent that it measures what it purports to measure (Carmines & Zeller 1979, pp.11-12). The LDQ is only valid, therefore, if it accurately measures dependence. High scores should represent high levels of dependence and low scores should represent low levels of dependence. Thus, even if the LDQ provides useful measures of consumption, or problems, but is still a poor tool for measuring dependence, it will have failed in its purpose.
In this research the validity of the LDQ has been tested in three ways: through concurrent validation, convergent validation, and finally, through "cultural validation". Each of these is discussed below.
The New Zealand populations studied in this research were New Zealand European/Pakeha, New Zealand Maori , and Pacific Nations. Each validity test was applied to the data supplied from within each population.

Concurrent Validation

Introduction

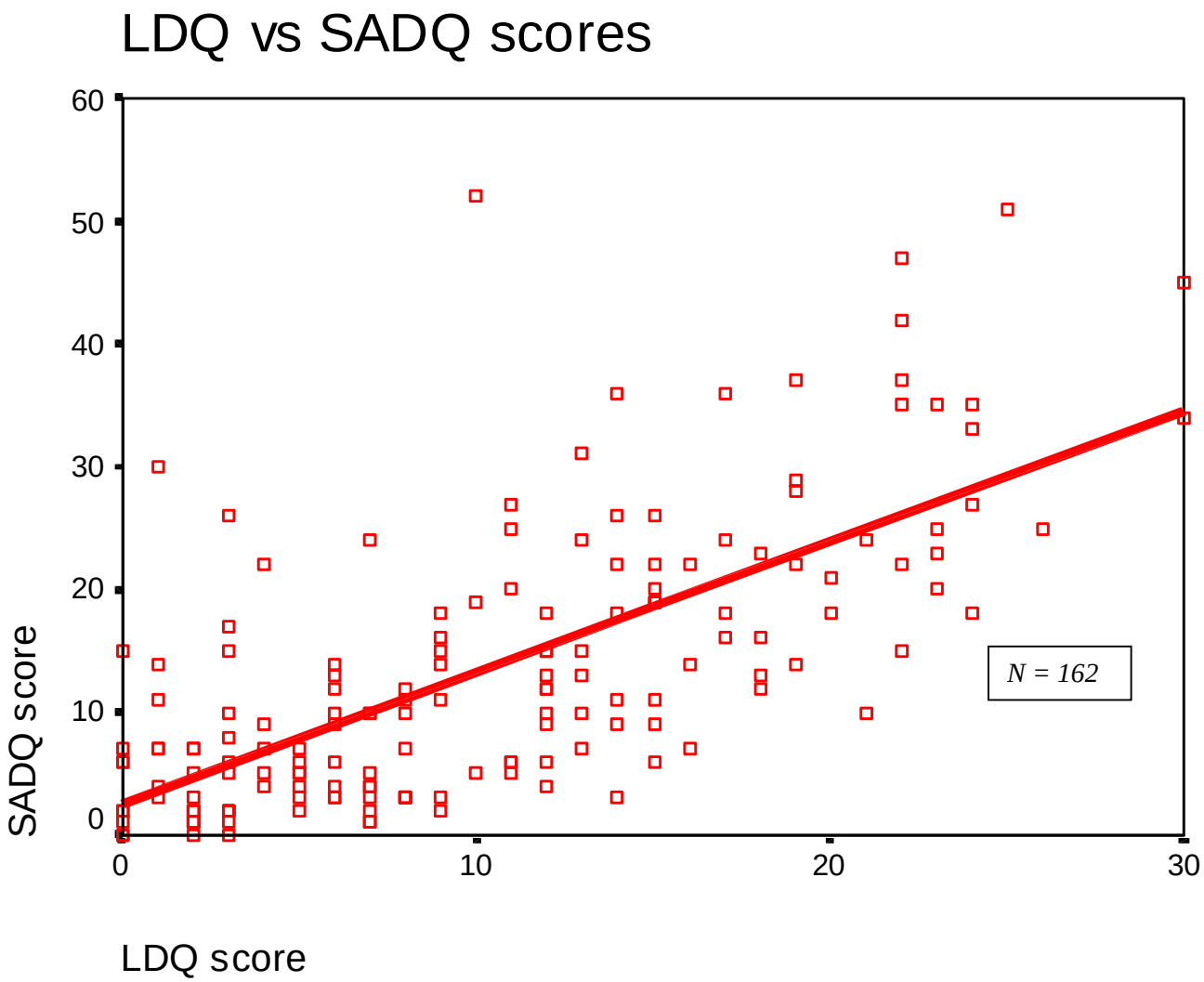
Concurrent validation examines the correlation between a test and other similar tests on one occasion (Kline 1979, p.11). For this research, the LDQ scores have been compared with scores obtained at the same time using the Severity of Alcohol Dependence Questionnaire (SADQ). Although the SADQ measures a psychobiological variant of dependence, and is thus not measuring exactly the same construct as the LDQ, it is considered close enough to be useful for this purpose. The SADQ has good psychometric credentials and is very widely used (Stockwell et al 1983; Meehan et al 1985).
This raises the obvious question, why use the LDQ when the SADQ is valid enough to act as a "gold standard"? As Kline notes, if other tests exist, then the new test must have some special worthwhile features (Kline 1979, p.11). The first response is that the LDQ is half the size of the SADQ which makes it easier to incorporate into briefer assessments and also makes it conceivable to use it as an outcome followup tool. A second response is that, unlike the SADQ, the LDQ includes alcohol dependence syndrome components such as salience of substance use, compulsion to start, compulsion to continue, and narrowing of using repertoire. A final response is that it may be possible to use the LDQ for measuring dependence upon a variety of substances.
In any case, the success of the LDQ in this test is determined by how closely it correlates to the SADQ score. In general terms, the higher the better, although it should be noted that the LDQ measures dependence over the previous week whereas the SADQ focuses on the previous 6 months. As mentioned earlier, there is also a difference in the specific construct of dependence used.

Overall Picture

The LDQ performs well for the concurrent validation test as compared against the SADQ for the three New Zealand populations combined. In general terms, when the SADQ identified a person as having a high level of dependence, the LDQ similarly produced a high score. Conversely, when the SADQ identified a person as having a low level of dependence, the LDQ also identified them as having a low level of dependence.

In statistical terms, a Spearman's correlation coefficient of 0.69 (n=162) was obtained. It was significant at the 0.001 level, 2 tailed. This is the same as was obtained by the Leeds Addiction Unit with their total sample of alcohol users (n=125).

As mentioned earlier, the LDQ focuses on the previous week while the SADQ focuses on the previous 6 months. This raised the possibility that the correlation would be lower than average for clients with low levels of consumption over the previous month before assessment and higher for the rest. This was indeed the case. Clients who consumed less than 20 standard drinks in the 4 weeks prior to assessment had a Spearman's correlation for their LDQ and SADQ scores of only 0.49 (n=37) whereas the remaining clients had a correlation of 0.75 (n=123). This finding suggests that the LDQ would have gained an even higher degree of support for its concurrent validity if it had been possible to test it against a tool with a similar time focus.

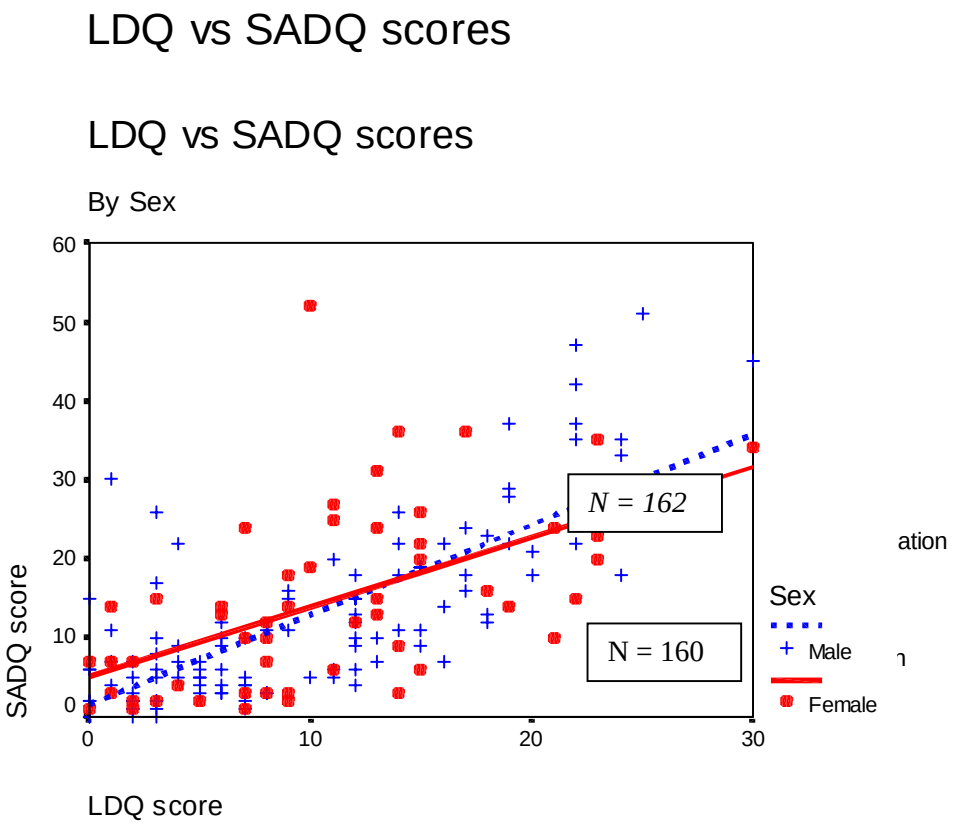


Ethnic Group

The LDQ also performs well in terms of concurrent validation for each New Zealand population studied. The Spearman's correlations obtained were as follows: New Zealand European 0.63 (n=85), New Zealand Maori 0.71 (n=41), Pacific Nation 0.58 (n=36). All were significant at the 0.001 level, 2 tailed.

Sex

Looking at gender, the LDQ also performed well. The Spearman's correlations were: Female 0.61 (n=53) and male



0.72 (n=109), both significant at the 0.001 level, 2 tailed.

Convergent Validation

In order to demonstrate convergent validation it is necessary to show that the test correlates highly with other variables with which it should theoretically correlate (Anastasi 1988, p.156). In this research, convergent validity has been assessed by looking at the degree of correlation between the LDQ ratings and the health scores produced by the SF-36 Health Survey (SF-36), between the LDQ ratings and the social functioning scores produced by the Social Problems Questionnaire (SPQ) (Corney & Clare 1985), and between the LDQ ratings and alcohol intake. Intake has been measured in two ways, both derived from the Timeline Follow-back technique (TLFB) (Sobell & Sobell 1996). Firstly, intake measured as grams of alcohol in the last using week; and secondly, intake measured in terms of the average weekly number of standard drinks consumed. As Raistrick et al note, 'the association between dependence on a substance and harmful consequences is recognised … The relationships of social problems and psychopathology to dependence can, therefore, be used as a measure of convergent validity'(Raistrick et al 1994, p.566).

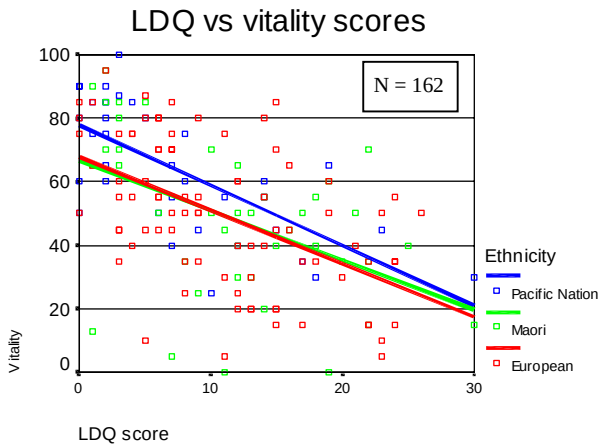
In general terms, the correlation coefficients obtained for these tests were lower than might have been expected. The Leeds Addiction Unit reported significant, but low to middle order, correlations between the LDQ, and the General Health Questionnaire (GHQ) and SPQ, with higher order correlations between the LDQ and intake measured in grams in the last using week. For alcohol, the correlations for the total sample were 0.51, 0.42, and 0.68 respectively (Raistrick et al 1994, p.567).

In our research, the SF-36 Health Survey was chosen in preference to the GHQ. Firstly, because the SF-36 has been validated for New Zealand populations (Medical Outcomes Trust 1994). Secondly, because an increasing amount of interest is being shown by New Zealand researchers in using the SF-36. The SF-36 has been incorporated, for example, into the recent National Health Survey of 8,000 New Zealanders.

Unlike the GHQ, the SF-36 cannot be summarised as a single score. Instead, the SF-36 produces 8 subscales. Separate correlations were generated for each of these. These ranged from -0.60 for vitality to -0.12 for physical functioning (see Table 1). The negative correlations provide some support for the LDQ's claims to convergent validity given that one might expect increased dependence to be associated with decreased health and vice versa.

It is a matter of interpretation as to how strongly these LDQ/SF-36 correlation coefficients support the convergent validity of the LDQ. Three of the 8 subscales had correlations of a larger magnitude than the 0.51 reported for the LDQ/GHQ by the Leeds Addiction Unit (-0.60, -0.59, -0.58), and 3 were just under (-0.48, -0.48, -0.47).

Of interest is the variability between different ethnic groups (see chart below). In general, the absolute magnitude of the coefficients for Maori and New Zealand European/Pakeha clients were lower than the average, with coefficients ranging from 0.00 to -0.60 for Maori and from -0.33 to -0.57 for New Zealand European/Pakeha. Pacific Nation clients scored above average more often than they scored below, e.g. -0.67 for vitality. Males and females alternated quite evenly about the average, ranging from -0.04 to 0.66 for male clients and from -0.31 to -0.55 for female clients (see



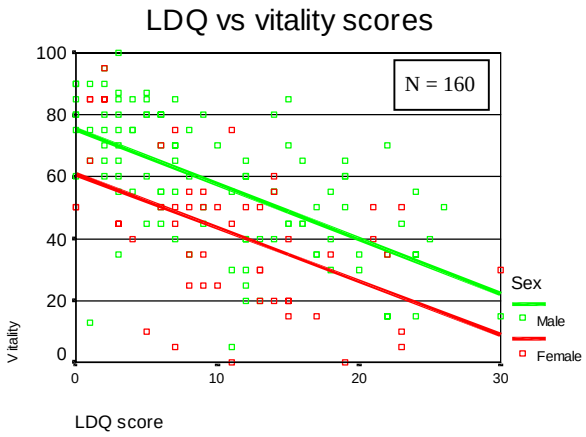


chart above).

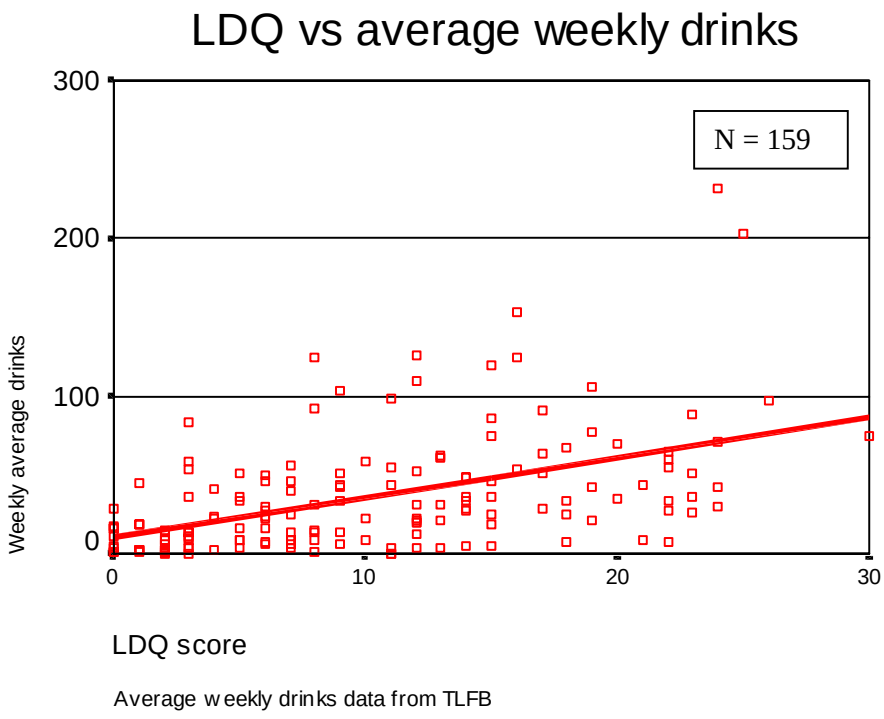
Looking at the SPQ (Table 2), the correlation was only 0.38 (n=162), significant at the 0.001 level, 2 tailed. This was similar to the 0.42 obtained by the Leeds Addiction Unit (Raistrick et al 1994, p.569). Interestingly, the coefficient for New Zealand European/Pakeha clients was just 0.28 (n=85) but for New Zealand Maori clients it was 0.47 (n=41), with Pacific Nation clients in the middle at 0.33 (n=36). These scores arguably provides further support, albeit weak, for the convergent validity of the LDQ

The correlations between the LDQ score and various measures of alcohol intake (Table 2) was the most surprising given the results reported by the Leeds Addiction Unit. Whereas the Leeds Addiction Unit reported a correlation coefficient of 0.68 for the total sample (0.54 for the followup sample of 25 at T1, and 0.72 at T2) between LDQ scores and intake measured in grams of alcohol in the previous using week, this study was only able to obtain a much more modest correlation of 0.39. At the very least this challenges the use of the LDQ as a partial surrogate for intake (see Raistrick et al 1994, pp.568-570).

Looking at the various subpopulations studied, the strongest relationship between intake measured over the last using week and dependence was obtained for Pacific Nation clients. New Zealand European/Pakeha clients scored close to the average whereas Maori clients scored well under with a statistically insignificant coefficient of 0.29. Male and female clients had similar correlation coefficients to each other.

The correlation between the LDQ and intake measured in terms of average weekly (standard) drinks was higher but still only reached 0.55 for the total study population (n=159).

It is also worth noting that the correlation coefficient was only 0.43 for New Zealand European/Pakeha clients who



make up the majority of clients seen in such settings.

Table 1 - Spearman correlation coefficients for LDQ and SF-36 subscales

Subscale	*Definition*	*Total sample*	*NZE*	*Maori*	*Pacific*	*Male*	*Female*
Vitality	Feeling energetic and full of pep versus feeling tired and worn out.	-0.60***	-0.52***	-0.45**	-0.67***	-0.63***	-0.52***
Social Functioning	Extent to which physical health or emotional problems interfere with normal social activities.	-0.59***	-0.51***	-0.60***	-0.57***	-0.66***	-0.44***
Mental Health	General mental health, including depression, anxiety, behavioural-emotional control, general positive effect.	-0.58***	-0.57***	-0.45**	-0.58***	-0.61***	-0.52***
Role Functioning - Physical	Extent to which physical health interferes with work or other daily activities, including accomplishing less than wanted, limitations in the kind of activities, or difficulty in performing activities.	-0.48***	-0.55***	-0.39*	-0.47**	-0.43***	-0.55***
General Health	Personal evaluation of health, including current health, health outlook, and resistance to illness.	-0.48***	-0.41***	-0.45**	-0.50**	-0.45***	-0.53***
Role Functioning - Emotional	Extent to which emotional problems interfere with work or other daily activities, including decreased time spent on activities, accomplishing less, and not working as carefully as usual.	-0.47***	-0.56***	-0.25NS	-0.48**	-0.46***	-0.47***
Bodily Pain	Intensity of pain and effect of pain on normal work, both inside and outside the home.	-0.43***	-0.40***	-0.43**	-0.33NS[3]	-0.45***	-0.34*
Physical Functioning	Extent to which health limits physical activities such as self-care, walking, climbing stairs, bending, lifting, and moderate and vigorous exercises.	-0.12 NS	-0.33**	0.00NS	0.07NS	-0.04NS	-0.31*

*** $p < 0.001$ ** $p < 0.01$ * $p < 0.05$

[3] p=0.0502033829689 exactly, i.e. very unlikely to be due to random variability even if it (marginally) fails the arbitrary cutoff point of 0.05.

Table 2 - Spearman correlation coefficients for LDQ vs SPQ, and two measures of intake

Measure	*Total sample*	*Leeds Addiction Unit*	*NZE*	*Maori*	*Pacific*	*Male*	*Female*
Social Problems Questionnaire	0.38***	0.42***	0.28**	0.47**	0.33*	0.44***	0.23NS
Intake - grams alcohol in previous using week	0.39***	0.68***	0.35**	0.29NS	0.49**	0.42***	0.36**
Intake - weekly average drinks (standard)	0.55***	-	0.43***	0.51***	0.65***	0.60***	0.47***

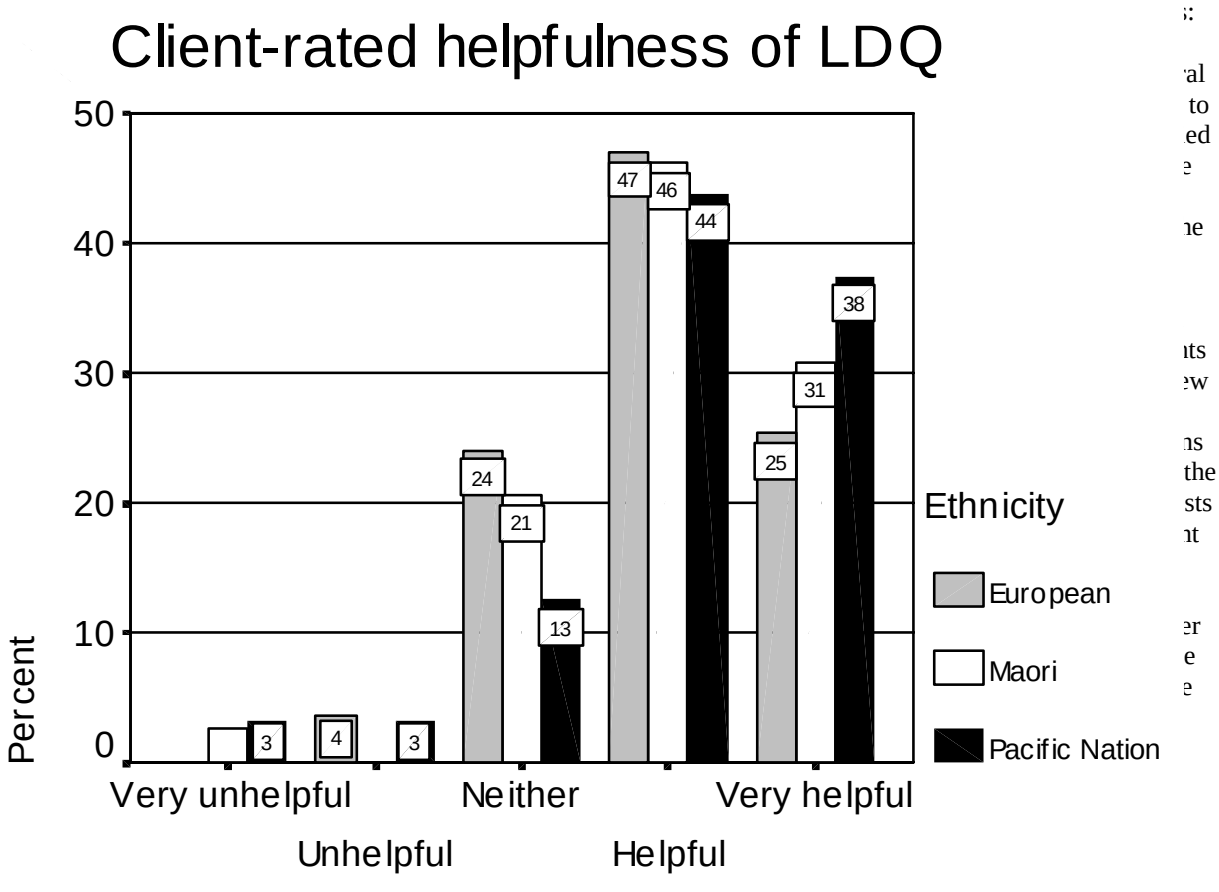
*** $p < 0.001$ ** $p < 0.01$ * $p < 0.05$

Interestingly, the SADQ produced better correlations than the LDQ against intake measured during the last using week. The correlation coefficient for the SADQ vs intake was 0.47 (n=159) as opposed to 0.39 (n= 159) for the LDQ vs intake - both significant at the 0.001 level, 2 tailed. The situation was largely reversed, however, when looking at intake over the previous week (whether or not alcohol was consumed during that week). The LDQ coefficient was 0.33 whereas the SADQ coefficient was only 0.15. The former was significant at the 0.001 level, 2 tailed; the latter was not statistically significant. The greater level of correlation obtained by the LDQ is perhaps what one might expect given that it focuses on dependence in the previous week only.

Once again, the data produces weak support for the convergent validation of the LDQ - both at a general level and for the three ethnic and two gender subpopulations. But should one expect strong correlations between dependence and other variables of this sort? After all, dependence should be conceived of as analytically distinct from both consumption levels and the social, health and other problems typically associated with consumption (Gossop et al 1995, pp.607-608). Admittedly, this is not to deny the presence of an empirical association (Gossop et al 1995, p.613) but perhaps one should only expect a modest degree of covariance. At the very least, the data presented here supports the disaggregation of these variables for clinical and research purposes.

Cultural Validation

The overriding finding of the research in this area is that the LDQ raises no significant cultural issues. There was no evidence that New Zealand European/Pakeha, New Zealand Maori, or Pacific Nations clients completed the



Clients were also invited in an open ended question to make "any further comments" on the LDQ. An analysis of these open-ended questions showed that all ethnic groups and genders found the tool to be equally acceptable. In fact, many comments demonstrated that the LDQ was well received. For example:

"It is a great indication in helping myself identify my personal problems and the extent in which they affect myself and other people"
Male Maori client
"Yes, I think it is helpful"
Female Maori client
"It is a good way of assessing people's alcohol level. It is very important for them to know and understand about how alcohol is affecting them in every way in life. I give the LDQ my full support and appreciate their concern in helping the community."
Male Pacific Nations client
"I found filling out this form was very good because of finding out for myself how well things are and also getting the chance to open up by writing it all down."
Female Pacific Nations client

Conclusion

The LDQ receives nearly as much support for its validity in this research as was received in the Leeds Addiction Unit's own research. Most importantly, the LDQ passed the concurrent validation test against the SADQ. The results were also similar to those obtained by the Leeds Addiction Unit in terms of convergent validation with the notable exception of intake measured in grams of alcohol in the last using week. The strong results for intake produced by the Leeds Addiction Unit were not replicated in this research. This finding supports the disaggregation of alcohol dependence, intake, social problems, and health for both clinical and research purposes.

More specifically, the LDQ has been validated for use with English-speaking New Zealand European/Pakeha, New Zealand Maori, and Pacific Nation clients in mainstream services. This is not to say, of course, that there is any reason to question the value of the LDQ with other New Zealand populations - only that this research has not settled the matter.

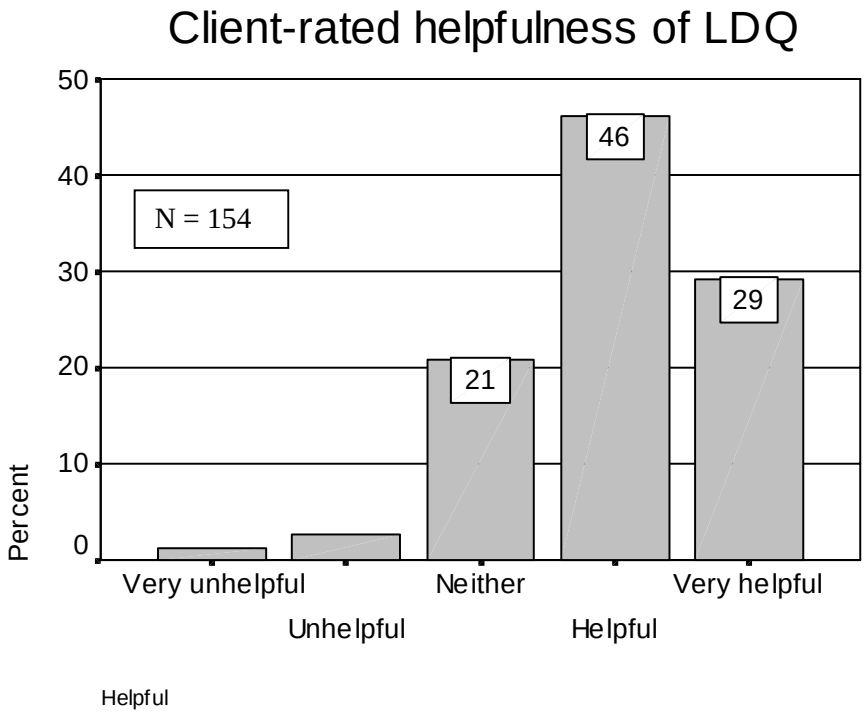
The LDQ Is Of Practical Use in a Clinical Setting When Used Appropriately

The LDQ is Brief and Simple to Use

The LDQ contains just 10 brief items and takes only a few minutes to complete. On the face of it, therefore, the LDQ would seem a practical means of measuring dependence in a clinical setting. The simplicity of the LDQ was tested in the research by seeking feedback from both staff and clients.

Staff feedback was elicited in two ways. Firstly, through the "Counsellor's LDQ Evaluation Checklist". The following questions were included in this survey: "Did any of the questions seem to make the client uncomfortable?"; "Did you have to repeat any questions?"; "Did the client misinterpret any questions?"; "Did any of the questions contain words or concepts that were not easily or consistently understood by clients?"; "Which questions were the most difficult or awkward for you to read? Have you come to dislike any questions? Why?"; "Did any of the questions seem to drag?"; "Were any of the answers given by the client contradicted elsewhere or at some later point?" None of the feedback received from counsellors through this survey (n=9) noted any problems with the application of the LDQ. Secondly, staff feedback was elicited through the 2 focus group interviews. Once again, there was little indication that clients had any difficulty with the LDQ.

Client feedback was sought through an open-ended question on the LDQ and through a rating of its perceived usefulness. None of the responses received by clients indicated any difficulties with the LDQ even though critical comments were sometimes made about other tools. In general, clients gave very good ratings for the helpfulness of the LDQ. Although the rating of helpfulness is not a direct test of its ease of use it supports the other evidence.



The LDQ is Best Used in Conjunction with Other Measures of Alcohol & Drug Problems

One finding, which came through strongly in the focus group interviews with staff, was that dependence should not be measured in isolation from other measures or assessments of alcohol problems. This is especially true in the case of the LDQ, which focuses on the previous week only. In one of the surveys completed by counsellors, a case was described where a client had ceased drinking a month prior to assessment. The LDQ gave a score of just 1 when answered (as required) with reference to the 1 week window but 22 when answered again with reference to a longer time span which incorporated the drinking period.

The main concern was that clients wishing to minimise their problems would embrace low dependence scores as if they represented a clean bill of health - even while there were still other important issues or problems.

> *"Just about all my clients were really low on the LDQ and I think it made me wary that it was minimising the consequences of their use by giving them a low score … I would have liked to see that they were abstinent for a number of reasons but the LDQ scoring low didn't give me backup to justify that"*
> ***Staff feedback in focus group interview***

It was partially in response to this concern that the RADS Research Unit included both the AUDIT and the LDQ in the Regional Alcohol & Drug Services triage screening package[4]. The AUDIT includes an assessment of risk and problems as well as dependence.

LDQ Scores Need Standard Interpretations for Clinical Purposes

One of the main themes which emerged in the focus group interviews conducted about the LDQ concerned the need for a guide to interpretation.

> *"I think people found it quite useful on its own (the LDQ) to just go through it, I think they were quite interested at that stage…. At the end* ***it doesn't make it very clear what it means for the client*** *so it was difficult to use that to full potential really… Something out of 30, what does that mean?"*
>
> ***Staff feedback in focus group interview (emphasis added)***

At present, the Leeds Addiction Unit has not yet established norms for the LDQ, even though it is planning to do so in the future (personal communication with Gillian Tober 27/1/99). In the meantime, the Leeds Addiction Unit's recommendation is simply to split the LDQ scores into 4 main groupings as follows:

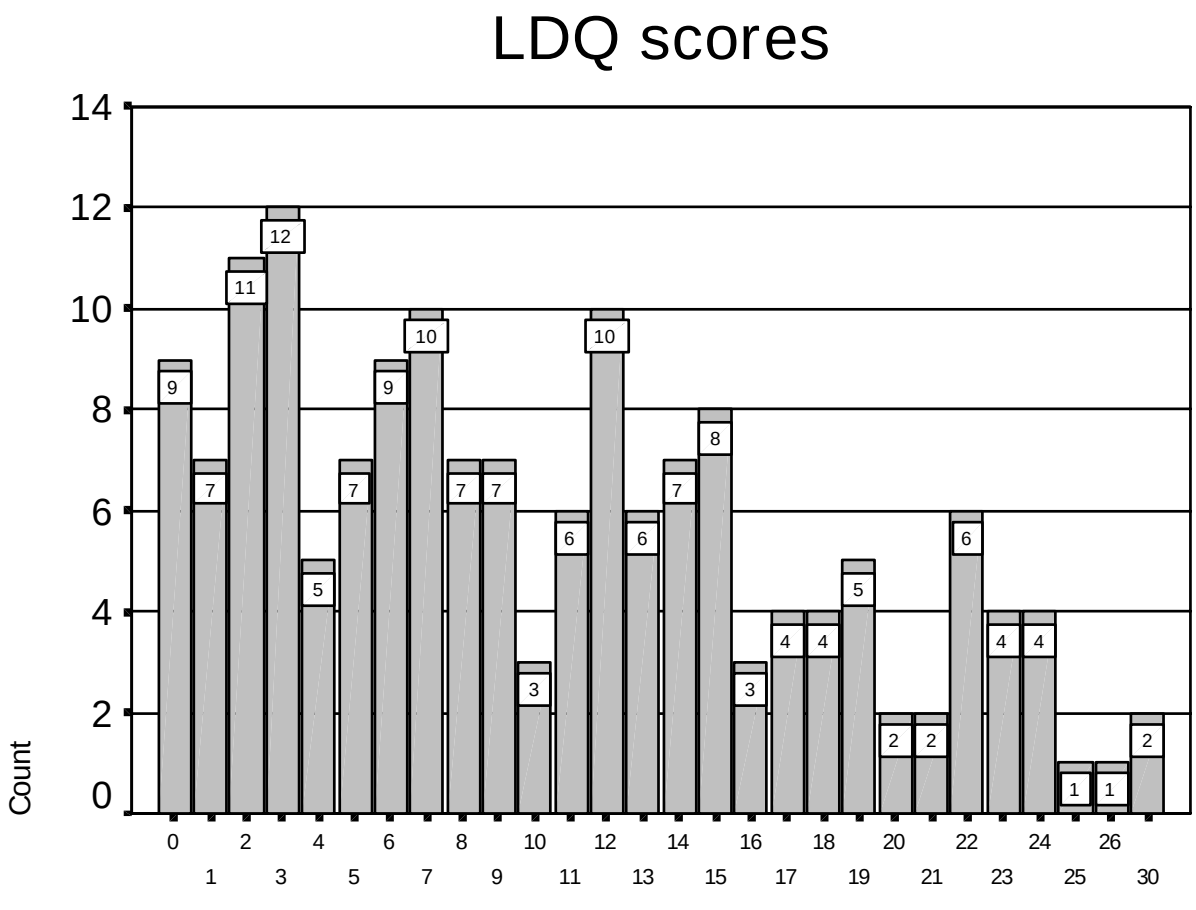
[4] The LDQ is only completed if the client either indicates an alcohol problem or scores over a certain level in the AUDIT (e.g. 8).

LDQ Scores	*Interpretations (preliminary)*
0	No dependence
1-10	Low to moderate dependence
11-20	Moderate to high dependence
21-30	High dependence

The LDQ is Likely to be Sensitive to Change

It was never intended in the design of this research project to intensively study the sensitivity of the LDQ to change over time. Ideally, such research would involve multiple measures over time - something which was not attempted in the design employed by the RADS Research Unit. Nevertheless, the cross-sectional data collected does support the use of the LDQ for the measurement of change. As was the case with the data collected by the Leeds Addiction Unit (Raistrick et al 1994, p.567), there was a considerable spread of scores obtained by the tool.

Further support for the ability of the LDQ to detect change came from both client and staff feedback. In several instances it was noted that significantly different scores would have been obtained if the survey had been asked at, or with reference to, an earlier period of time.



"If these questions applied to 3 months ago I would probably have scored 30. Since I've been exercising the answers to the questions have changed, due to the survey being from last week"
Client feedback

The LDQ is Likely to be Useful for Outcome Measurement

Outcome measurement usually involves measurement at several points in time. For the most useful results, one of these measurements should ideally be taken some time after treatment concludes so that it is possible to identify lasting effects. Outside of the context of specialist research projects this can be difficult to achieve. Generally speaking, it is only possible to collect data from clients at a followup point by telephone or by using postal surveys. Either way, for such activities to be successful it is critical that the tools used are brief and easily understood by clients. Being just 10 items long the LDQ is highly suited to the task of measuring the dependence component of outcome.

Other tools or questions are probably necessary, however, to assess other aspects of outcome. Although part of the rationale for designing the LDQ was to "circumvent the need to estimate intake for the purpose of evaluating outcome" (Raistrick et al 1994, pp.569-570) the correlations between various measures of alcohol intake and the LDQ score in this study have all been rather moderate. As has already been reported, the correlation between the LDQ and alcohol intake measured in grams for the previous using week was just 0.39. For New Zealand Maori clients the correlation was even lower at 0.29 and for the New Zealand European/Pakeha majority it was just 0.35. The correlation coefficients for the other measure of alcohol intake used, average weekly drinks, was higher at 0.55 but still fell below the level achieved by the Leeds Addiction Unit for the LDQ vs intake measured in grams of alcohol in the last using week. Once again, the New Zealand European/Pakeha majority scored lower than the total population with a correlation coefficient of just 0.43. The evidence to date, therefore, does not support using the LDQ as a surrogate measure of intake.

Other aspects of outcome beyond dependence and intake presumably also require separate assessment, even if it is only in the form of brief but unvalidated open-ended or closed-response questions.

One further point in the favour of using the LDQ for outcome measurement is its fine-grained nature as discussed earlier. Sensitivity to change is critical for an outcome measurement tool comparing scores at two points of time. It would be impossible to conclude anything useful about an intervention if the tools used to evaluate it were inherently incapable of identifying changes of the magnitude one was interested in.

In conclusion, therefore, the results of this study support the use of the LDQ *as part of* an assessment and post-treatment outcome measurement package for routine use by specialist alcohol and drug treatment services.

The LDQ Provides Sound Measures of Alcohol Dependence

This research, together with the research conducted by the Leeds Addiction Unit, provides ample support for the use of the LDQ with alcohol. The LDQ provides a brief instrument for measuring dependence which can be delivered in a range of ways. But how good is the LDQ as a measure of dependence on other, or multiple drugs? This is an important question given that the Leeds Addiction Unit's intention was to create a tool capable of measuring dependence on a variety of substances (Raistrick et al 1994, p.563).

A conservative verdict is that the LDQ's credentials for measuring opiate dependence are less well established - at least in terms of the data published on the LDQ to date. The correlation between the LDQ and the Severity of Opiate Dependence Questionnaire (SODQ) was only 0.30 which provides rather limited support for the LDQ's concurrent validity. The correlations with the GHQ, SPQ, and intake were just 0.33, 0.27, and 0.12 respectively, which provides very limited support for convergent validity as well (Raistrick et al 1994, p.569). In addition, the LDQ has not (yet) been validated for other illicit drugs.

This is not the same, however, as saying that the LDQ is inappropriate for use with other drugs or that it fails to measure dependence for other drugs accurately. It remains possible that the LDQ has excellent properties in this regard. The low correlation with the SODQ may reflect the limits of the SODQ as much as those of the LDQ. According to the Leeds Addiction Unit, the LDQ has content validity that the SODQ lacks. The LDQ is also claimed to have good construct validity because of the way in which it was developed (pers comm. Gillian Tober 3 May 1999).

This possible limitation of the LDQ need not be problematic, however, given the existence of the Severity of Dependence Scale (SDS). The SDS comprises just 5 items and is not intended as a competitor for measures of alcohol dependence (Gossop et al 1995, p.608). It should be possible therefore, given the brevity of both the LDQ and the SDS, to use both together to cover both alcohol and other drugs. Indeed, RADS has recently begun using a brief triage screening package which applies this formula.

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APPENDIX 1 - ITEM ANALYSIS OF THE LDQ

Cronbach's coefficient alpha was calculated for the total population, and for each of the main subpopulations (see table below). The overall result was very similar to that of the Leeds Addiction Unit (LAU) (0.92 for this data vs 0.94 for the LAU)[5]. When looking for the "weakest" questions, however, the results were different. The Leeds Addiction Unit identified questions 5 and 8 as being the weakest with correlations of 0.66 and 0.69 respectively. In contrast, question 8 performed very well in this research, with a correlation of 0.76. Additionally, question 6 stood out as being the weakest with correlations as low as 0.40 and 0.48 for Maori and Females respectively.

Table 3 - Cronbach's coefficient alpha and weakest questions for each population

[5] 49 opiate users were included with the alcohol users in the Leeds Addiction Unit calculation of internal consistency (Raistrick et al 1994, p.568).

	Total sample	***Leeds Addiction Unit***	***NZE***	***Maori***	***Pacific***	***Male***	***Female***
Cronbach's coefficient alpha	0.92	0.94	0.91	0.91	0.93	0.92	0.90
Questions with low correlations with total LDQ score	Q6 (0.59)	Q5 (0.66)	Q5 (0.55)	Q6 (0.40)	Q3 (0.61)	Q6 (0.64)	Q6 (0.48)
Item-total correlation - Q5	0.65	0.66	0.55	0.73	0.79	0.64	0.68
Item-total correlation - Q8	0.76	0.69	0.75	0.74	0.78	0.77	0.72

APPENDIX 2 - CHARACTERISTICS & REPRESENTATIVENESS OF THE STUDY POPULATION

Table 4 - Characteristics of different populations

	Auckland Regional Alcohol & Drug Services - Study Population (n = 162)	*Auckland Regional Alcohol & Drug Services - Client Population*	*Leeds Addiction Unit[6] - Study Population - TOTAL Sample (n=125)*	*Leeds Addiction Unit - Study Population - Clinic Sample (n=47)*	*Leeds Addiction Unit - Study Population - Student Sample (n=64)*	*Leeds Addiction Unit - Study Population - GP Sample (n=14)*
Age ± SD	31.5 ± 11.9	34.8 ± 11.9	29.2	38.6 ± 12.7	22.8 ± 3.4	26.9 ± 8.1
Gender - % male	67%	57%	56%	61%	56%	43%
Ethnicity - % New Zealand European/Pakeha	53%	66%	-	-	-	-
Ethnicity - % New Zealand Maori	25%	24%	-	-	-	-
Ethnicity - % Pacific Nations	22%	5%[7]	-	-	-	-
LDQ ± SD	10.3 ± 7.4	-	10.1	16.3 ± 8.9	7.0 ± 4.4	3.1 ± 3.2
SADQ ± SD	13.5 ± 11.4	-	14.2	29 ±16.7	5.9 ± 6.1	2.6 ± 4.5
SPQ ± SD	2.6 ± 2.2	-	4.6	7.1 ± 4.9	3.5 ± 3.6	1.4 ± 1.9
Intake (g alcohol) ± SD	422 ± 516	-	510.6	983 ± 1007	251 ± 189	111 ± 90

[6] All data for the Leeds Addiction Unit is derived from Raistrick et al 1994. Even though the Leeds Addiction Unit only reported this data for separate subpopulations, it was possible to calculate the mean for the total population given the data provided about the separate means and the separate sample sizes.

[7] The remaining 5% is distributed amongst other ethnic groups.

Table 5 - SF-36 Health Survey Scores of the Study Population

	Auckland Regional Alcohol & Drug Services - Study Population (n = 162)
SF-36 - Physical Functioning ± SD	79 ± 28
SF-36 - Role Functioning - Physical ± SD	63 ± 40
SF-36 - Bodily Pain ± SD	73 ± 28
SF-36 - General Health ± SD	64 ± 24
SF-36 - Vitality ± SD	52 ± 24
SF-36 - Social Functioning ± SD	61 ± 30
SF-36 - Role Functioning - Emotional ± SD	48 ± 41
SF-36 - Mental Health ± SD	56 ± 22

In terms of age and gender, the study population closely resembles the total population of clients served by Regional Alcohol & Drug Services. The proportion of New Zealand Maori and New Zealand European/Pakeha is also broadly representative. The main difference is the proportion of Pacific Nation clients. This group was deliberately overrepresented for the purposes of statistical power but still only represents 22% of the total sample.
It is recognised that the clients studied are not representative of all potential clients. Many potential clients do not access services as they are currently provided. It must be noted, however, that this research has provided valuable information on the validity of the LDQ for those members of the populations studied currently accessing services - an important group relevant to all "mainstream" providers. It is possible that it will be similarly useful for non-presenting people but this will have to be tested separately.
Another useful comparison is that between the Regional Alcohol & Drug Services and the Leeds Addiction Unit (LAU) study populations. Understanding the similarities and differences increases the ability to interpret the statistical results about the LDQ. Looking at the available demographic data, the populations are very close in terms of average age (31.5 for RADS, 29.2 for LAU) and comparable in terms of the proportion of males (67% for RADS, 57% for LAU) (Raistrick et al 1994, p.568).
Turning to the results of the various instruments used, the similarities are surprisingly strong, especially for the LDQ and SADQ measures of dependence. The greatest difference was in the level of social problems reported, with the Leeds Addiction Unit study population reporting a higher level of social problems (Raistrick et al 1994, p.568).
The results of the SF-36 Health Survey are included as a general contribution to national data on different populations. In addition to the National Health Survey, the RADS Research Unit has SF-36 data on over 250 methadone clients. As time progresses it will be possible to make a series of useful comparisons.

APPENDIX 3 - METHODOLOGY

Selecting and training participating staff

Instead of using special researchers to administer the assessment package (including the LDQ, SADQ, SF-36, SPQ, and TLFB), it was decided to use our existing clinical staff. The main advantage of this approach is that validity can be assessed for the LDQ under realistic circumstances - i.e. with typical clients, typical staff, and in a typical context. This is appropriate given that we never validate a measuring instrument - merely the use to which it is put (Nunnally 1967, p.76).
An attempt was made to match clients to therapists by both ethnicity (in terms of the three broad categories used) and gender. This was considered very important for New Zealand Māori clients according to He Kamaka Oranga. On the grounds that the characteristics of the interviewer can have a marked impact on the validity of results their recommendation was to use New Zealand
Māori staff for New Zealand Māori clients. Dr Colin Tukuitonga, Senior Lecturer, Department of Māori & Pacific Health, made the same point about New Zealand Pacific clients.

In total, over 30 clinical staff were involved. They were all trained in the use of the psychometric research instruments, the Survey Evaluation Checklist, and the other administrative tasks associated with the project - for example, introducing the project to clients, collecting consent details, etc. A brief presentation was also given on the potential uses of the LDQ in assessment and treatment planning. A training video was used to explain the Timeline Follow-back (TLFB) technique for measuring alcohol consumption.

Recruiting and selecting clients

According to the protocol followed, all clients presenting to Regional Alcohol & Drug Services who were assigned to participating counsellors through the standard referral and assessment processes and met various criteria were to be invited to participate in the research by their counsellor. Suitable clients had to be experiencing problems with alcohol (even if their other drug problems were more severe); speak English adequately for the purposes of answering a survey; be considered capable of attending the assessment in a non-intoxicated state; not be suffering any severe illness or disability (physical or psychological) which might interfere with their ability to complete the interview; and belong to either the New Zealand European/Pakeha, New Zealand Maori, or Pacific Nations ethnic groups.

The first requirement arose out of the need to have an accurate measure of substance intake to validate the LDQ against. Measurement of retrospective alcohol intake is more developed than that for other substances. The Timeline Follow-back (TLFB) method for assessing levels of alcohol consumption which is being used is well established and suitable for research work (Sobell & Sobell 1996). Retrospective measurements of other substances are much more problematic. The Leeds Addiction Unit found it “almost impossible”, for example, to obtain an accurate measure of opiate intake. The authors acknowledged that even in a research setting there are ‘problems of purity and nature of “street” drugs, problems accounting for multiple and varied methods of use and problems finding equivalents between opiates with different potencies and pharmacokinetics’ (Raistrick et al 1994, p.570).

The second requirement was included because there is currently no validated version of the LDQ available in Māori or any of the Pacific languages. It is recognised that the language requirement has important implications for the generalisability of the research. The LDQ has only been validated for English-speaking members of the three ethnic groups studied. Additional research will be needed if validation is to be extended.

The subsequent two requirements, sobriety and the absence of physical or psychological impediments, were included for practical reasons, and the final requirement, membership of one of the three main ethnic groups listed, was included because these were the three groups for whom research is being conducted. It is recognised that the ethnic category “New Zealand Pacific” is very broad and that there are major and significant differences within it. An analysis of the client assessment records of RADS for the last year showed that any attempt to break this grouping down into specific nationalities - e.g. Samoan, Tongan etc - or to focus on just one Pacific ethnic group would make it impractical to reach the sample sizes required for statistical testing within an acceptable timeframe. This was especially true when the numbers of women within each Pacific nationality were examined. There would be insufficient Samoan women, for example, to allow an analysis of gender as well as of ethnicity. It was decided, therefore, to group the various Pacific nationalities for the purposes of this research. It was felt that this would not significantly undermine the validity of the research on the LDQ in the same way as it might for other types of research - e.g. on sexuality; family life; religious experience etc. This research answers a very broad question about the potential validity of the LDQ for the most commonly encountered client groups in “mainstream” services.

Subjects were recruited to create three subgroups according to ethnicity - New Zealand European/Pakeha, New Zealand Māori, and Pacific Nation clients. Each group had both male and female subjects. Clients were then asked to read an information sheet and sign a consent form.

Data collection

Standard practice is for clients arriving at RADS to be given an assessment interview by the counsellor assigned to them. This was the point at which clients were given the assessment package. In some cases, the package was delivered in a second or subsequent session; in other cases, staff experimented with having clients complete portions of the package at home - most commonly the Timeline Follow-back technique (TLFB).

Clients were then asked to complete the LDQ, the SADQ, the SF-36 Health Survey, and the SPQ. Following this, staff helped clients to construct a retrospective picture of their alcohol consumption using the TLFB.

The TLFB provides a picture of people’s retrospective reports of drinking over a designated time period. Specially developed techniques are used to enhance recall. The TLFB method has been shown to have good psychometric properties with a variety of drinker groups (Sobell & Sobell 1996; Sobell & Sobell 1992; Sobell et al 1988). When the TLFB method was tested against biochemical tests, verifiable events such as hospitalisations and arrests, collateral informant’s reports of subjects’ drinking, survey studies, and measures of alcohol-related consequences it was found to be suitably accurate for research purposes (Sobell & Sobell 1996, pp.25-30). The calendar and standard drinks conversion chart were modified for the New Zealand context.

In addition to the assessment data collected, the following client details were collected: age, sex, and ethnic identity (including specific Pacific Nation in the case of Pacific Nation clients).

The SADQ was for the purposes of measuring concurrent validity; and the SF-36 Health Survey and the SPQ for the purposes of measuring convergent validity. With the exception of the SF-36 Health Survey, these were the instruments

used by the Leeds Addiction Unit in its research (refer to the discussion of convergent validation for an explanation of the reasons for using the SF-36 in preference to the General Health Questionnaire (GHQ)). The rationale for following the Leeds Addiction Unit's design as closely as possible was to facilitate comparison of the data.
The SADQ was chosen in preference to the Severity of Dependence Scale (SDS) for two reasons. Firstly, because the SADQ is the more established and widely tested instrument of the two. The authors of the SDS recently noted the need for further research on its validity in clinical settings (Gossop et al 1995, p.613). Secondly, because the SDS was not designed to measure dependence on alcohol where existing alternatives are available (Gossop et al 1995, p.612). This is a critical point given that this research, as was discussed earlier, will be restricted to clients who have alcohol as one of the substances for which they are seeking treatment. This restriction arises out of the need to have an accurate measure of substance intake to validate the LDQ against.
It was reasonable to expect that the instruments used would be sufficiently valid for the New Zealand populations included in the study. The SF-36 Health Survey was recently validated for the general New Zealand population (Medical Outcomes Trust 1994) and was specifically evaluated in 1995 by the Health & Disability Analysis Unit, Midland Health, for use with New Zealand Māori populations (Kokaua et al 1995). The face validity of the SF-36 for New Zealand Māori populations was also assessed by Harry Pitman in his capacity as Manager, Māori Services Development, RADS, who piloted it with 8 New Zealand Māori clients. The SADQ was developed for Australian populations so it is arguably satisfactory for New Zealand populations. Harry Pitman thought this had sufficient validity for New Zealand Māori populations. The same conclusion was reached vis-à-vis the SPQ. In any case, no other suitable instruments have been validated with New Zealand Māori or Pacific populations.
In general terms, the use of the instruments described for assessing the LDQ was considered acceptable by the following people consulted:

- *Te Kani Kingi*, Te Pumanawa Hauora - Māori Studies Department, Massey University
- *Dr Colin Tukuitonga*, Senior Lecturer, Department of Māori & Pacific Health, School of Medicine, University of Auckland/ Public Health Medicine Specialist, North Health
- *Christina Tapu*, manager of the Pacific Island Unit at Middlemore Hospital
- *Therese Weir*, Organisation Change Co-ordinator and *Bill Takerei*, Service Co-ordinator from He Kamaka Oranga - the Māori Corporate Unit at Greenlane Hospital. *Wi Keelin*, Manager of Manawanui and Community Health Services was also present.
- *Sandra Major* of Waipareira Trust
- *Martin Uruamo Mariassouce*, Te Kaiwhakarite at Te Puni Kōkiri
- *Kerry Hinni*, Manager of Health Services at the Orakei Marae
- *Tony Iwikau*, Māori Services Co-ordinator, RADS.

During the assessments, counsellors observed client experiences of the LDQ. To assist with this process, counsellors were issued a survey evaluation checklist (see following appendices). The following questions were included: "Did any of the questions seem to make the client uncomfortable?"; "Did you have to repeat any questions?"; "Did the client misinterpret any questions?"; "Did any of the questions contain words or concepts that were not easily or consistently understood by clients?"; "Which questions were the most difficult or awkward for you to read? Have you come to dislike any questions? Why?"; "Did any of the questions seem to drag?"; "Were any of the answers given by the client contradicted elsewhere or at some later point?" Fowler recommends a systematic approach of this sort even though the traditional manner has been to have semi-formal meetings at which perceptions and experiences are discussed. A survey makes it possible to focus attention on the issues most relevant to validity rather than on those which pose practical problems for survey administrators (Fowler 1995, p.121).
At the end of the session, counsellors asked clients a few questions about their experience of the LDQ. These included a question about the perceived helpfulness of the tool.
The final data collection task was to gather staff feedback on the clinical use of the LDQ. It was decided to use a focus group methodology for this purpose. This methodology is an appropriate way of gathering research data when applied properly (Krueger 1994, p.19). Two focus group meetings were organised to document and explore the way in which the LDQ was used in assessment and treatment planning during the assessment interview. Although focus groups have traditionally been comprised of people unknown to each other, this is not essential (Krueger 1994, pp.211-213). Having said this, however, it is recognised that the use of colleagues, some of them known to each other, can raise some special issues (Krueger 1994, pp.211-213). In this case, none of these were expected to be significant. The staff involved were all comparable in terms of their hierarchical position within the organisation (at the time of the research at least) and they were selected from a variety of different work teams (See Krueger 1994, p.213).
The RADS Senior Researcher, Dr Grant Paton-Simpson, and the RADS Clinical Researcher, Stuart MacKinnon, alternated as moderator and assistant moderator at the two focus group sessions. The role of the assistant moderator was to tape the meetings and take notes (See Krueger 1994, pp.111-113).

Questions followed a basic sequence (Appendix 8). At the end, participant verification of any conclusions drawn about utilisation was sought (see Krueger 1994, p.128). Immediately after the sessions, debriefing occurred between the moderator and assistant moderator to capture first impressions (see Krueger 1994, p.128). As with the focus group discussions themselves, these debriefing sessions were taped and transcribed (see Krueger 1994, p.134).

APPENDIX 4 - PARTICIPANT INFORMATION SHEET

Evaluation of the Leeds Dependence Questionnaire (LDQ) 4

Information on the Research

The Alcohol Advisory Council (ALAC) is looking at ways of **improving the quality of alcohol and drug treatment in New Zealand**. Encouraging the use of standard surveys asking clients about health, drug use, and so on is one way of achieving this.

Before introducing a survey it is important that it is tested in New Zealand. A survey which works for American clients may not work for New Zealanders. It is also important to check that a survey works for key subgroups within New Zealand such as New Zealand European, New Zealand Maori, and Pacific Island groups.

This research is being funded by ALAC to test the Leeds Dependence Questionnaire. Key issues will be validity - does the survey actually measure dependence - and usefulness for client assessment.

Three groups of clients are being invited to take part - New Zealand European, New Zealand Maori, and Pacific Island clients. To take part you must have experienced some problems with alcohol (not necessarily severe) and be able to read English.

This is <u>your</u> invitation to take part in this research. YOU DO NOT HAVE TO TAKE PART IN THIS RESEARCH IF YOU DO NOT WANT TO. If you do not take part this will not negatively affect your treatment or any other relations with the service. If you change your mind you can ask to take part later.

If you do want to take part all you have to do is fill in five surveys: the Leeds Dependence Questionnaire, a survey asking about alcohol dependence, a health survey, a survey about your life more generally, and a survey on drinking patterns. This should take around **45 minutes**. Your counsellor will then briefly discuss the results of the Leeds Dependence Questionnaire with you.

Your confidentiality is completely protected. The information you provide will be entered into a secure computer so that the usefulness of the Leeds Dependence Questionnaire can analysed. After that, because the information you provide may be useful to you and your counsellor in the future, your interview material will be stored in your personal file which is stored strictly according to the Privacy Act 1993.

No one will be able to identify you, or your information when the research findings are produced. This is because the research report will be focusing on **group** results, **not on individuals**.

If you are interested in the results or wish to know more about the research, please phone Dr. Grant Paton-Simpson 3777-394. If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, Auckland, phone 09-623-5799.

APPENDIX 5 - ASSESSMENT PACKAGE

Booklet 1 - Leeds Dependence Questionnaire Interview Booklet
Booklet 2 - LDQ Project Timeline Followback Interview Booklet

Client Name: _____

Leeds Dependence Questionnaire Interview Booklet

CONTENTS

THANKS FOR Y

Thank you for expressing interest in the Le
Included in this package is an information sheet describing the project for you to read first. If you still feel comfortable about being involved, please sign the consent form on the next page.

What next?
In this booklet are four questionnaires which ask you about your alcohol use, your general health, and problems you may have experienced as part of your drinking.
Simply follow the instructions for each questionnaire.
Most of the questions involve putting a circle around different answers to questions. Sometimes you may find that the options offered in the questions do not quite match your experience are seem to be for someone older or younger than you. In this case, just choose the answer that is most like your experience.
If you are unsure about any question, put a "X" beside it and discuss it with your counsellor when you meet.

What do with the booklet when I have finished?
Bring the booklet in with you when you see your counsellor.

What if I want to fill it out with my counsellor?

If you do not want to fill this out by yourself, no problem. You can always fill it out at the beginning of your appointment with your counsellor if you like.

CONSENT FORM FOR RESEARCH

Title of project: **Evaluation of the Leeds Dependence Questionnaire (LDQ)**

Principal investigator: **Dr Grant Paton-Simpson**

Name of patient or subject: _____ Age: _____ (years)

- I have heard and understood an explanation of the research project I have been invited to take part in.
- I have been given and I have read, a written explanation of what is asked of me, and I have had an opportunity to ask questions and to have them answered.
- I understand that I may withdraw from the project at any time and that, if I do, my medical care will not be affected in any way.
- I understand that my consent to take part does not alter my legal rights.
- I consent to take part as a subject in this research.

Signed: _____ (subject)

In my opinion consent was given freely and with understanding.

_____ Witness name (please print)

_____ Witness signature

_____ Date

Consent obtained by:

_____ _____

Name Signature

LEEDS DEPENDENCE QUESTIONNAIRE - *LDQ*

In answering this questionnaire:

- think about the last week
- think about your use of ALCOHOL,
- circle the answer that's most appropriate to you.

	Never	Sometimes	Often	Nearly always
1) Do you find yourself thinking about when you will next be able to have another drink?	0	1	2	3
2) Is drinking more important than anything else you might do during the day?	0	1	2	3
3) Do you feel your need for drink is too strong to control?	0	1	2	3
4) Do you plan your days around getting drink and drinking?	0	1	2	3
5) Do you drink in a particular way in order to	0	1	2	3

increase the effect it gives you?				
6) Do you drink morning, afternoon and evening?	0	1	2	3
7) Do you feel you have to carry on drinking once you have started?	0	1	2	3
8) Is getting the effect you want more important than the particular drink you use?	0	1	2	3
9) Do you want to drink more when the effect starts to wear off?	0	1	2	3
10) Do you find it difficult to cope with life without drink?	0	1	2	3

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE
SADQ

Have you drunk any alcohol in the past six months? YES / NO
If YES, please answer all the following questions about your drinking by circling your most appropriate response.

Section A - ICQ

DURING THE PAST <u>SIX MONTHS</u>

	Never or Almost Never	**Sometimes**	**Often**	**Nearly always**
1) After having just two or three drinks I felt like having a few more.	0	1	2	3
2) After having two or three drinks I could stop drinking if I had other things to do.	3	2	1	0
3) When I started drinking alcohol I found it hard to stop until I was fairly drunk.	0	1	2	3
4) When I went drinking I planned to have at least six drinks.	0	1	2	3
5) When I went drinking I planned to have no more than two or three drinks.	3	2	1	0

Section B - SADQ - Form C

Please answer all the following questions about your drinking by circling your most appropriate response.

DURING THE PAST SIX MONTHS:

	Never or Almost Never	Sometimes	Often	Nearly always
1) The day after drinking alcohol, I woke up feeling sweaty.	0	1	2	3
2) The day after drinking alcohol, my hands shook first thing in the morning.	0	1	2	3
3) The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.	0	1	2	3
4) The day after drinking alcohol, I woke up absolutely drenched in sweat.	0	1	2	3
5) The day after drinking alcohol, I dreaded waking up in the morning.	0	1	2	3
6) The day after drinking alcohol, I was frightened of meeting people first thing in the morning.	0	1	2	3
7) The day after drinking alcohol, I felt at the edge of despair when I awoke.	0	1	2	3
8) The day after drinking alcohol, I felt very frightened when I awoke.	0	1	2	3

DURING THE PAST SIX MONTHS:

	Never or Almost Never	Sometimes	Often	Nearly always
9) The day after drinking alcohol, I liked to have an alcoholic drink in the morning.	0	1	2	3
10) The day after drinking alcohol, in the morning I always gulped my first few alcoholic drinks down as quickly as possible.	0	1	2	3
11) The day after drinking alcohol, I drank more alcohol in the morning to get rid of the shakes.	0	1	2	3
12) The day after drinking alcohol, I had a very strong craving for an alcoholic drink when I awoke.	0	1	2	3
13) I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 7 medium glasses of beer).	0	1	2	3
14) I drank more than half a bottle of spirits in a day (OR 2 bottles of wine OR 30 medium glasses of beer).	0	1	2	3
15) I drank more than one bottle of spirits in a day (OR 4 bottles of wine OR 30 medium glasses of beer).	0	1	2	3
16) I drank more than two bottles of spirits in a day (OR 8 bottles of wine OR 60 medium glasses of beer).	0	1	2	3

Section C

IMAGINE THE FOLLOWING SITUATION:

1. You have HARDLY DRUNK ANY ALCOHOL FOR A FEW WEEKS.
2. You then drink VERY HEAVILY for TWO DAYS.

HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF HEAVY DRINKING?

	Not at All	**Slightly**	**Moderately**	**Quite a Lot**
17) I would start to sweat.	0	1	2	3
18) My hands would shake.	0	1	2	3
19) My body would shake.	0	1	2	3
20) I would be craving for a drink.	0	1	2	3

SF-36 HEALTH SURVEY

INSTRUCTIONS: This questionnaire asks for your views about your health, how you feel and how well you are able to do your usual activities.
Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. <u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?

(circle one)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse than one year ago	4
Much worse now than one year ago	5

3. The following questions are about activities you might do during a typical day.
Does <u>your health now limit you</u> in these activities? If so, how much?

(circle one number on each line)

ACTIVITIES	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited At All
a) **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
b) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	1	2	3
c) Lifting or carrying groceries.	1	2	3
d) Climbing **several** flights of stairs.	1	2	3
e) Climbing **one** flight of stairs.	1	2	3
f) Bending, kneeling, or stooping.	1	2	3
g) Walking **more than one kilometre**.	1	2	3
h) Walking **half a kilometre**.	1	2	3
i) Walking **100 metres**.	1	2	3
j) Bathing or dressing yourself.	1	2	3

4. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

(circle one number on each line)

	YES	NO
a) Cut down on the **amount of time** you spent on work or other activities.	1	2
b) **Accomplished less** than you would like.	1	2
c) Were limited in the **kind** of work or other activities.	1	2
d) **Had difficulty** performing the work or other activities (for example, it took extra effort).	1	2

5. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a) Cut down the **amount of time** you spent on work or other activities.	1	2
b) **Accomplished** less than you would like.	1	2
c) Didn't do work or other activities as carefully as usual.	1	2

6. During the <u>past 4 weeks</u>, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(circle one)

Not at all 1
Slightly 2
Moderately..... 3
Quite a bit 4
Extremely 5

7. How much <u>bodily</u> pain have you had during the <u>past 4 weeks</u>?

(circle one)

No bodily pain 1
Very mild..... 2
Mild 3
Moderate..... 4
Severe 5
Very severe..... 6

8. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?

(circle one)

Not at all 1
A little bit..... 2
Moderately..... 3
Quite a bit 4
Extremely 5

9. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u> -

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a) Did you feel full of life?	1	2	3	4	5	6

b) Have you been a very nervous person?	1	2	3	4	5	6
c) Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d) Have you felt calm and peaceful?	1	2	3	4	5	6
e) Did you have a lot of energy?	1	2	3	4	5	6
f) Have you felt down?	1	2	3	4	5	6
g) Did you feel worn out?	1	2	3	4	5	6
h) Have you been a happy person?	1	2	3	4	5	6
i) Did you feel tired?	1	2	3	4	5	6

10. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

All of the time..... 1
Most of the time..... 2
Some of the time..... 3
A little of the time..... 4
None of the time 5

11. How TRUE or FALSE is <u>each</u> of the following statements for your?

(circle one number on each line)

	Definitely True	**Mostly true**	**Don't Know**	**Mostly False**	**Definitely False**
a) I seem to get sick a little easier than other people.	1	2	3	4	5
b) I am as healthy as anybody I know.	1	2	3	4	5
c) I expect my health to get worse.	1	2	3	4	5
d) My health is excellent.	1	2	3	4	5

SOCIAL PROBLEM QUESTIONNAIRE - *SPQ*

♦ Please circle the number under the most appropriate answer.

A. Housing (Everyone answer)

1)	Are your housing conditions adequate for you and your family's needs?	*Adequate* *0*	*Slightly inadequate* *1*	*Markedly inadequate* *2*	*Severely inadequate* *3*
2)	How satisfied are you with your present accommodation?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

B. Work

FOR ALL MEN AND WOMEN WORKING OUTSIDE THE HOME

Tick box if not applicable Ã

3)	How satisfied are you with your present job?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*
4)	Do you have problems getting on with any of the people at your work?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*

FOR PRIMARY CAREGIVERS* WITH NO OUTSIDE WORK

Tick box if not applicable Ã

5)	How satisfied are you with being a caregiver?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

* In a couple relationship, the "Primary Caregiver" is the person with the **most responsibility** for the day-to-day care of children. If you feel that this role is equally shared between you and your partner and you think this question applies to you them go ahead and answer it. Otherwise please tick " not applicable" box.

FOR PRIMARY CAREGIVERS WITH A FULL OR PART-TIME JOB OUTSIDE THE HOME

Tick box if not applicable Ã

6)	How satisfied are you with working and running a home?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

FOR THOSE WHO ARE NOT WORKING (RETIRED, UNEMPLOYED, OR OFF SICK)

Tick box if not applicable Ã

7)	How satisfied are you with this situation?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

C. Financial Circumstances (Everyone answer)

8)	Is the money coming in adequate for you and your family's needs?	*Adequate* *0*	*Slightly inadequate* *1*	*Markedly inadequate* *2*	*Severely inadequate* *3*
9)	Do you have any difficulties in meeting bills and other financial commitments?	*No difficulties* *0*	*Slight difficulties* *1*	*Marked difficulties* *2*	*Severe difficulties* *3*
10)	How satisfied are you with your financial position?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

D. Social Contacts (Everyone answer)

11)	How satisfied are you with the amount of time you are able to go out?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*
12)	Do you have any problems with your neighbours?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*
13)	Do you have any problems getting on with any of your friends?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*
14)	How satisfied are you with the amount of time you see your friends?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*
15)	Do you have any problems getting on with any close relative? (include parents, in-laws or grown-up children)	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*
16)	How satisfied are you with the amount of time you see your relatives?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

E. Marriage and partners

17) What is your marital status?	*Single* *1*	*Married/ cohabiting* *2*	*Widowed* *3*	*Separated* *4*	*Divorced* *5*

FOR ALL THOSE WHO ARE MARRIED OR WHO HAVE A STEADY RELATIONSHIP

Tick box if not applicable Ã

18) Do you have difficulty confiding in your partner?	*No difficulties* *0*	*Slight difficulties* *1*	*Marked difficulties* *2*	*Severe difficulties* *3*
19) Are there any sexual problems in your relationship?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*
20) Do you have any other problems getting on together?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*
21) How satisfied in general are you with your relationships?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*
22) Have you recently been so dissatisfied that you have considered separating from your partner?	*No* *0*	*Sometimes* *1*	*Often* *2*	*Yes, planned or recent separation* *3*

FOR ALL THOSE WHO ARE NOT MARRIED/DO NOT HAVE A STEADY RELATIONSHIPS

Tick box if not applicable Ã

23) How satisfied are you with this situation?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

F. Domestic Life

FOR THOSE WITH CHILDREN UNDER 18

Tick box if not applicable Ã

24) Do you have any difficulties coping with your children?	*No difficulties* *0*	*Slight difficulties* *1*	*Marked difficulties* *2*	*Severe difficulties* *3*
25) How satisfied do you feel with your relationship with the children?	*Satisfied*	*Slightly dissatisfied*	*Markedly dissatisfied*	*Severely dissatisfied*

	0	*1*	*2*	*3*

FOR THOSE WITH CHILDREN OF SCHOOL AGE

Tick box if not applicable Ã

26) Are there any problems involving your children at school?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*

FOR ALL THOSE WITH OTHER ADULTS LIVING WITH THEM (INCLUDING RELATIVES BUT EXCLUDING SPOUSE)

Tick box if not applicable Ã

27) Do you have any problems about sharing household tasks?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*
28) Do you have any difficulties with the other adults in your household?	*No difficulties* *0*	*Slight difficulties* *1*	*Marked difficulties* *2*	*Severe difficulties* *3*
29) How satisfied are you with this arrangement?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

G. Legal Matters (everyone answer)

30) Do you have any legal problems (custody, maintenance, compensation, etc)?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*

H. For those who are living alone

Tick box if not applicable Ã

31) Do you have any difficulties living and managing on your own?	*No difficulties* *0*	*Slight difficulties* *1*	*Marked difficulties* *2*	*Severe difficulties* *3*
32) How satisfied are you with living on your own?	*Satisfied* *0*	*Slightly dissatisfied* *1*	*Markedly dissatisfied* *2*	*Severely dissatisfied* *3*

I. Other (Everyone answer)

33) Do you have any other social problems or problems?	*No Problems* *0*	*Slight Problems* *1*	*Marked Problems* *2*	*Severe Problems* *3*

If so, please specify ...

_____

LEEDS DEPENDENCE QUESTIONNAIRE – LDQ
WHAT DID YOU THINK OF IT?

Final Questions

Finally, please think for a moment about the ten LDQ questions you answered at the beginning of this booklet (on page 4). The purpose of the LDQ is to indicate your level of alcohol dependence by giving you a score out of 30. To get this score simply add up all the numbers you have circled. Write your score in the box provided: ☐

1a. ***When you consider your actual drinking, is the score higher or lower than you expected?***

Higher	☐	1
About right	☐	2
Lower	☐	3

1b. How would you rate your own problem with alcohol?

Below is a line with "No problem" on one end and "Extreme problem" on the other. Please place an r on the line to indicate how you rate your problem.

***No** problem with alcohol* ***Extreme** problem with alcohol*

2. How helpful do you think the LDQ has been as a part of your assessment?

Very helpful	☐	1
Helpful	☐	2
Neither helpful or unhelpful	☐	3
Unhelpful	☐	4
Very unhelpful	☐	5

3. Have you any final comments you would like to make about the LDQ?

_____

_____

_____

THANK YOU FOR ANSWERING THESE QUESTIONS

LDQ Project Timeline Followback Interview Booklet

Client Name: _____

Client Number: _____

Gender: M / F

Age: _____

Ethnicity: _____

Pacific Nation: _____

Interview Date: __ / __ / __

Interview Site: _____

Counsellor: _____

TLFB Alcohol Use Assessment
(Counsellor Instructions)

This is the second booklet of the two Leeds Project Interview booklets. *The purpose of this booklet is to gather the approximate number of standard drinks drunk by a client for the three months prior to the assessment.* It has three parts:

Client Information Page
This page contains brief introductory information for clients.
At the bottom of the page there are some questions you MUST ask clients.

TLFB Calendar Section
This section contains a 15 month calendar which the client will use to enter the amounts they have been drinking prior to assessment. It has New Zealand public and school holidays and other commemorative days marked on it to act as memory cues.

90 Day TLFB Assessment Dates
This section contains a table which you use to establish the three month (90 day) window of alcohol use you are assessing.

Example:

A client is being assessed on Tuesday, January 6th, 1998.
Select the last and first drinking days to be recorded from the table.
Mark the calendar clearly so that the client is not confused about what days to record.

	Assessment Date	*Last day to record*	*First day to record*
January	Thursday 01 Jan	Wednesday 31 Dec	Thursday 02 Oct
	Friday 02 Jan	Thursday 01 Jan	Friday 03 Oct
	Monday 05 Jan	Sunday 04 Jan	Monday 06 Oct
	Tuesday 06 Jan	Monday 05 Jan	Tuesday 07 Oct
	Wednesday 07 Jan	Tuesday 06 Jan	Wednesday 08 Oct
	Thursday 08 Jan	Wednesday 07 Jan	Thursday 09 Oct
	Friday 09 Jan	Thursday 08 Jan	Friday 10 Oct
	Monday 12 Jan	Sunday 11 Jan	Monday 13 Oct

Assessment date.

The last drinking day they need to record.

The first drinking day they need to record.

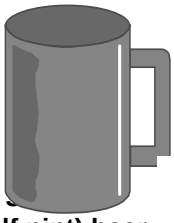
REMEMBER: Quick reference notes on the TLFB method are available in your "LDQ Project Counsellor's Handbook & Diary"

TLFB Alcohol Use Assessment
(Client Information)

Counsellor Reads…

I am now going to ask you to think about your drinking for the last three months so that we can get a picture of how much you have been drinking and look for patterns over this time. The numbers of drinks for each drinking day you can recall will be entered into a computer program and a summary report will be made available to you.

Because alcoholic drinks vary, counsellors and researchers usually use a measure called a "Standard Drink". ***These are some examples of standard drinks***



(half pint) beer

or

100 mls
(small) wine

or

50 mls
sherry/liqueur

or

30 mls
(single) spirits

Example: If you have four ½ pints of beer and double "rum & coke" then you have had about **6** standard drinks.

QUESTIONS FOR THE CLIENT

These questions I am asking you now will be used by the Timeline Followback program to produce your personal report.

1. What is the maximum number of drinks you have consumed in a single day during the past three months?:	_____
2. Occasionally, people drink in the morning to avoid withdrawal symptoms from the previous night's drinking. This is sometimes called "relief drinking." Have you engaged in "relief drinking" during the last 90 days?: (Circle)	Y / N
3. When you think about the cost of your drinking, what is the average cost of having a single drink **at home**?:	$_____
4. When you think about the cost of your drinking, what is the average cost of having a single drink **at a bar**?:	$_____

Timeline Followback Calendar

OCTOBER 1997

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
			1	2	3	4
5 Daylight saving starts	6	7	8	9	10	11
12 School holidays finish	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31 Halloween	

NOVEMBER 1997

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
						1
2	3	4 Melbourne Cup Day	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER 1997

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22 School holidays start	23	24	25 Christmas Day	26 Boxing Day	27
28	29	30	31 New Year's Eve			

JANUARY 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
				1 New Year's Day	2 New Year's Holiday	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26 Auckland Anniversary	27 School holidays finish	28	29	30	31

FEBRUARY 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
1	2	3	4	5	6 Waitangi Day	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

MARCH 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15 Daylight Saving Ends	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
			1	2	3	4
5	6	7	8	9	10 Good Friday	11 School holidays start
12 Easter Sunday	13 Easter Monday	14	15	16	17	18
19	20	21	22	23	24	25 ANZAC Day
26 School holidays finish	27	28	29	30		

MAY 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

JUNE 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
	1 Queen's Birthday	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

JULY 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
			1	2	3	4 School holidays start
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19 School holidays finish	20	21	22	23	24	25
26	27	28	29	30	31	

AUGUST 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

SEPTEMBER 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26 School holidays start
27	28	29	30			

OCTOBER 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
				1	2	3
4 Daylight saving starts	5	6	7	8	9	10
11 School holidays finish	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26 Labour Day	27	28	29	30	31 Halloween

NOVEMBER 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 1998

Sun	*Mon*	*Tues*	*Wed*	*Thur*	*Fri*	*Sat*
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17 School holidays start	18	19
20	21	22	23	24	25 Christmas Day	26 Boxing Day
27	28	29	30	31		

90 Day TLFB Assessment Dates

	Assessment Date	*Last day to record*	*First day to record*
January	Thursday 01 Jan	Wednesday 31 Dec	Thursday 02 Oct
	Friday 02 Jan	Thursday 01 Jan	Friday 03 Oct
	Monday 05 Jan	Sunday 04 Jan	Monday 06 Oct
	Tuesday 06 Jan	Monday 05 Jan	Tuesday 07 Oct
	Wednesday 07 Jan	Tuesday 06 Jan	Wednesday 08 Oct
	Thursday 08 Jan	Wednesday 07 Jan	Thursday 09 Oct
	Friday 09 Jan	Thursday 08 Jan	Friday 10 Oct
	Monday 12 Jan	Sunday 11 Jan	Monday 13 Oct
	Tuesday 13 Jan	Monday 12 Jan	Tuesday 14 Oct
	Wednesday 14 Jan	Tuesday 13 Jan	Wednesday 15 Oct
	Thursday 15 Jan	Wednesday 14 Jan	Thursday 16 Oct
	Friday 16 Jan	Thursday 15 Jan	Friday 17 Oct
	Monday 19 Jan	Sunday 18 Jan	Monday 20 Oct
	Tuesday 20 Jan	Monday 19 Jan	Tuesday 21 Oct
	Wednesday 21 Jan	Tuesday 20 Jan	Wednesday 22 Oct
	Thursday 22 Jan	Wednesday 21 Jan	Thursday 23 Oct
	Friday 23 Jan	Thursday 22 Jan	Friday 24 Oct
	Monday 26 Jan	Sunday 25 Jan	Monday 27 Oct
	Tuesday 27 Jan	Monday 26 Jan	Tuesday 28 Oct
	Wednesday 28 Jan	Tuesday 27 Jan	Wednesday 29 Oct
	Thursday 29 Jan	Wednesday 28 Jan	Thursday 30 Oct
	Friday 30 Jan	Thursday 29 Jan	Friday 31 Oct
February	Monday 02 Feb	Sunday 01 Feb	Monday 03 Nov
	Tuesday 03 Feb	Monday 02 Feb	Tuesday 04 Nov
	Wednesday 04 Feb	Tuesday 03 Feb	Wednesday 05 Nov
	Thursday 05 Feb	Wednesday 04 Feb	Thursday 06 Nov
	Friday 06 Feb	Thursday 05 Feb	Friday 07 Nov
	Monday 09 Feb	Sunday 08 Feb	Monday 10 Nov
	Tuesday 10 Feb	Monday 09 Feb	Tuesday 11 Nov
	Wednesday 11 Feb	Tuesday 10 Feb	Wednesday 12 Nov
	Thursday 12 Feb	Wednesday 11 Feb	Thursday 13 Nov
	Friday 13 Feb	Thursday 12 Feb	Friday 14 Nov

	Assessment Date	*Last day to record*	*First day to record*
	Monday 16 Feb	Sunday 15 Feb	Monday 17 Nov
	Tuesday 17 Feb	Monday 16 Feb	Tuesday 18 Nov
	Wednesday 18 Feb	Tuesday 17 Feb	Wednesday 19 Nov
	Thursday 19 Feb	Wednesday 18 Feb	Thursday 20 Nov
	Friday 20 Feb	Thursday 19 Feb	Friday 21 Nov
	Monday 23 Feb	Sunday 22 Feb	Monday 24 Nov
	Tuesday 24 Feb	Monday 23 Feb	Tuesday 25 Nov
	Wednesday 25 Feb	Tuesday 24 Feb	Wednesday 26 Nov
	Thursday 26 Feb	Wednesday 25 Feb	Thursday 27 Nov
	Friday 27 Feb	Thursday 26 Feb	Friday 28 Nov
March	Monday 02 Mar	Sunday 01 Mar	Monday 01 Dec
	Tuesday 03 Mar	Monday 02 Mar	Tuesday 02 Dec
	Wednesday 04 Mar	Tuesday 03 Mar	Wednesday 03 Dec
	Thursday 05 Mar	Wednesday 04 Mar	Thursday 04 Dec
	Friday 06 Mar	Thursday 05 Mar	Friday 05 Dec
	Monday 09 Mar	Sunday 08 Mar	Monday 08 Dec
	Tuesday 10 Mar	Monday 09 Mar	Tuesday 09 Dec
	Wednesday 11 Mar	Tuesday 10 Mar	Wednesday 10 Dec
	Thursday 12 Mar	Wednesday 11 Mar	Thursday 11 Dec
	Friday 13 Mar	Thursday 12 Mar	Friday 12 Dec
	Monday 16 Mar	Sunday 15 Mar	Monday 15 Dec
	Tuesday 17 Mar	Monday 16 Mar	Tuesday 16 Dec
	Wednesday 18 Mar	Tuesday 17 Mar	Wednesday 17 Dec
	Thursday 19 Mar	Wednesday 18 Mar	Thursday 18 Dec
	Friday 20 Mar	Thursday 19 Mar	Friday 19 Dec
	Monday 23 Mar	Sunday 22 Mar	Monday 22 Dec
	Tuesday 24 Mar	Monday 23 Mar	Tuesday 23 Dec
	Wednesday 25 Mar	Tuesday 24 Mar	Wednesday 24 Dec
	Thursday 26 Mar	Wednesday 25 Mar	Thursday 25 Dec
	Friday 27 Mar	Thursday 26 Mar	Friday 26 Dec
	Monday 30 Mar	Sunday 29 Mar	Monday 29 Dec
	Tuesday 31 Mar	Monday 30 Mar	Tuesday 30 Dec

	Assessment Date	*Last day to record*	*First day to record*
April	Wednesday 01 Apr	Tuesday 31 Mar	Wednesday 31 Dec
	Thursday 02 Apr	Wednesday 01 Apr	Thursday 01 Jan
	Friday 03 Apr	Thursday 02 Apr	Friday 02 Jan
	Monday 06 Apr	Sunday 05 Apr	Monday 05 Jan
	Tuesday 07 Apr	Monday 06 Apr	Tuesday 06 Jan
	Wednesday 08 Apr	Tuesday 07 Apr	Wednesday 07 Jan
	Thursday 09 Apr	Wednesday 08 Apr	Thursday 08 Jan
	Friday 10 Apr	Thursday 09 Apr	Friday 09 Jan
	Monday 13 Apr	Sunday 12 Apr	Monday 12 Jan
	Tuesday 14 Apr	Monday 13 Apr	Tuesday 13 Jan
	Wednesday 15 Apr	Tuesday 14 Apr	Wednesday 14 Jan
	Thursday 16 Apr	Wednesday 15 Apr	Thursday 15 Jan
	Friday 17 Apr	Thursday 16 Apr	Friday 16 Jan
	Monday 20 Apr	Sunday 19 Apr	Monday 19 Jan
	Tuesday 21 Apr	Monday 20 Apr	Tuesday 20 Jan
	Wednesday 22 Apr	Tuesday 21 Apr	Wednesday 21 Jan
	Thursday 23 Apr	Wednesday 22 Apr	Thursday 22 Jan
	Friday 24 Apr	Thursday 23 Apr	Friday 23 Jan
	Monday 27 Apr	Sunday 26 Apr	Monday 26 Jan
	Tuesday 28 Apr	Monday 27 Apr	Tuesday 27 Jan
	Wednesday 29 Apr	Tuesday 28 Apr	Wednesday 28 Jan
	Thursday 30 Apr	Wednesday 29 Apr	Thursday 29 Jan
May	Friday 01 May	Thursday 30 Apr	Friday 30 Jan
	Monday 04 May	Sunday 03 May	Monday 02 Feb
	Tuesday 05 May	Monday 04 May	Tuesday 03 Feb
	Wednesday 06 May	Tuesday 05 May	Wednesday 04 Feb
	Thursday 07 May	Wednesday 06 May	Thursday 05 Feb
	Friday 08 May	Thursday 07 May	Friday 06 Feb
	Monday 11 May	Sunday 10 May	Monday 09 Feb
	Tuesday 12 May	Monday 11 May	Tuesday 10 Feb
	Wednesday 13 May	Tuesday 12 May	Wednesday 11 Feb
	Thursday 14 May	Wednesday 13 May	Thursday 12 Feb
	Friday 15 May	Thursday 14 May	Friday 13 Feb
	Monday 18 May	Sunday 17 May	Monday 16 Feb
	Tuesday 19 May	Monday 18 May	Tuesday 17 Feb
	Wednesday 20 May	Tuesday 19 May	Wednesday 18 Feb
	Thursday 21 May	Wednesday 20 May	Thursday 19 Feb
	Friday 22 May	Thursday 21 May	Friday 20 Feb
	Monday 25 May	Sunday 24 May	Monday 23 Feb
	Tuesday 26 May	Monday 25 May	Tuesday 24 Feb
	Wednesday 27 May	Tuesday 26 May	Wednesday 25 Feb
	Thursday 28 May	Wednesday 27 May	Thursday 26 Feb
	Friday 29 May	Thursday 28 May	Friday 27 Feb
June	Monday 01 Jun	Sunday 31 May	Monday 02 Mar
	Tuesday 02 Jun	Monday 01 Jun	Tuesday 03 Mar
	Wednesday 03 Jun	Tuesday 02 Jun	Wednesday 04 Mar
	Thursday 04 Jun	Wednesday 03 Jun	Thursday 05 Mar
	Friday 05 Jun	Thursday 04 Jun	Friday 06 Mar
	Monday 08 Jun	Sunday 07 Jun	Monday 09 Mar
	Tuesday 09 Jun	Monday 08 Jun	Tuesday 10 Mar
	Wednesday 10 Jun	Tuesday 09 Jun	Wednesday 11 Mar
	Thursday 11 Jun	Wednesday 10 Jun	Thursday 12 Mar
	Friday 12 Jun	Thursday 11 Jun	Friday 13 Mar
	Monday 15 Jun	Sunday 14 Jun	Monday 16 Mar
	Tuesday 16 Jun	Monday 15 Jun	Tuesday 17 Mar
	Wednesday 17 Jun	Tuesday 16 Jun	Wednesday 18 Mar
	Thursday 18 Jun	Wednesday 17 Jun	Thursday 19 Mar
	Friday 19 Jun	Thursday 18 Jun	Friday 20 Mar
	Monday 22 Jun	Sunday 21 Jun	Monday 23 Mar
	Tuesday 23 Jun	Monday 22 Jun	Tuesday 24 Mar
	Wednesday 24 Jun	Tuesday 23 Jun	Wednesday 25 Mar
	Thursday 25 Jun	Wednesday 24 Jun	Thursday 26 Mar
	Friday 26 Jun	Thursday 25 Jun	Friday 27 Mar
	Monday 29 Jun	Sunday 28 Jun	Monday 30 Mar
	Tuesday 30 Jun	Monday 29 Jun	Tuesday 31 Mar

	Assessment Date	*Last day to record*	*First day to record*
July	Wednesday 01 Jul	Tuesday 30 Jun	Wednesday 01 Apr
	Thursday 02 Jul	Wednesday 01 Jul	Thursday 02 Apr
	Friday 03 Jul	Thursday 02 Jul	Friday 03 Apr
	Monday 06 Jul	Sunday 05 Jul	Monday 06 Apr
	Tuesday 07 Jul	Monday 06 Jul	Tuesday 07 Apr
	Wednesday 08 Jul	Tuesday 07 Jul	Wednesday 08 Apr
	Thursday 09 Jul	Wednesday 08 Jul	Thursday 09 Apr
	Friday 10 Jul	Thursday 09 Jul	Friday 10 Apr
	Monday 13 Jul	Sunday 12 Jul	Monday 13 Apr
	Tuesday 14 Jul	Monday 13 Jul	Tuesday 14 Apr
	Wednesday 15 Jul	Tuesday 14 Jul	Wednesday 15 Apr
	Thursday 16 Jul	Wednesday 15 Jul	Thursday 16 Apr
	Friday 17 Jul	Thursday 16 Jul	Friday 17 Apr
	Monday 20 Jul	Sunday 19 Jul	Monday 20 Apr
	Tuesday 21 Jul	Monday 20 Jul	Tuesday 21 Apr
	Wednesday 22 Jul	Tuesday 21 Jul	Wednesday 22 Apr
	Thursday 23 Jul	Wednesday 22 Jul	Thursday 23 Apr
	Friday 24 Jul	Thursday 23 Jul	Friday 24 Apr
	Monday 27 Jul	Sunday 26 Jul	Monday 27 Apr
	Tuesday 28 Jul	Monday 27 Jul	Tuesday 28 Apr
	Wednesday 29 Jul	Tuesday 28 Jul	Wednesday 29 Apr
	Thursday 30 Jul	Wednesday 29 Jul	Thursday 30 Apr
	Friday 31 Jul	Thursday 30 Jul	Friday 01 May
August	Monday 03 Aug	Sunday 02 Aug	Monday 04 May
	Tuesday 04 Aug	Monday 03 Aug	Tuesday 05 May
	Wednesday 05 Aug	Tuesday 04 Aug	Wednesday 06 May
	Thursday 06 Aug	Wednesday 05 Aug	Thursday 07 May
	Friday 07 Aug	Thursday 06 Aug	Friday 08 May
	Monday 10 Aug	Sunday 09 Aug	Monday 11 May
	Tuesday 11 Aug	Monday 10 Aug	Tuesday 12 May
	Wednesday 12 Aug	Tuesday 11 Aug	Wednesday 13 May
	Thursday 13 Aug	Wednesday 12 Aug	Thursday 14 May

	Assessment Date	*Last day to record*	*First day to record*
	Friday 14 Aug	Thursday 13 Aug	Friday 15 May
	Monday 17 Aug	Sunday 16 Aug	Monday 18 May
	Tuesday 18 Aug	Monday 17 Aug	Tuesday 19 May
	Wednesday 19 Aug	Tuesday 18 Aug	Wednesday 20 May
	Thursday 20 Aug	Wednesday 19 Aug	Thursday 21 May
	Friday 21 Aug	Thursday 20 Aug	Friday 22 May
	Monday 24 Aug	Sunday 23 Aug	Monday 25 May
	Tuesday 25 Aug	Monday 24 Aug	Tuesday 26 May
	Wednesday 26 Aug	Tuesday 25 Aug	Wednesday 27 May
	Thursday 27 Aug	Wednesday 26 Aug	Thursday 28 May
	Friday 28 Aug	Thursday 27 Aug	Friday 29 May
	Monday 31 Aug	Sunday 30 Aug	Monday 01 Jun
September	Tuesday 01 Sep	Monday 31 Aug	Tuesday 02 Jun
	Wednesday 02 Sep	Tuesday 01 Sep	Wednesday 03 Jun
	Thursday 03 Sep	Wednesday 02 Sep	Thursday 04 Jun
	Friday 04 Sep	Thursday 03 Sep	Friday 05 Jun
	Monday 07 Sep	Sunday 06 Sep	Monday 08 Jun
	Tuesday 08 Sep	Monday 07 Sep	Tuesday 09 Jun
	Wednesday 09 Sep	Tuesday 08 Sep	Wednesday 10 Jun
	Thursday 10 Sep	Wednesday 09 Sep	Thursday 11 Jun
	Friday 11 Sep	Thursday 10 Sep	Friday 12 Jun
	Monday 14 Sep	Sunday 13 Sep	Monday 15 Jun
	Tuesday 15 Sep	Monday 14 Sep	Tuesday 16 Jun
	Wednesday 16 Sep	Tuesday 15 Sep	Wednesday 17 Jun
	Thursday 17 Sep	Wednesday 16 Sep	Thursday 18 Jun
	Friday 18 Sep	Thursday 17 Sep	Friday 19 Jun
	Monday 21 Sep	Sunday 20 Sep	Monday 22 Jun
	Tuesday 22 Sep	Monday 21 Sep	Tuesday 23 Jun
	Wednesday 23 Sep	Tuesday 22 Sep	Wednesday 24 Jun
	Thursday 24 Sep	Wednesday 23 Sep	Thursday 25 Jun
	Friday 25 Sep	Thursday 24 Sep	Friday 26 Jun
	Monday 28 Sep	Sunday 27 Sep	Monday 29 Jun
	Tuesday 29 Sep	Monday 28 Sep	Tuesday 30 Jun

	Assessment Date	*Last day to record*	*First day to record*
	Wednesday 30 Sep	Tuesday 29 Sep	Wednesday 01 Jul
October	Thursday 01 Oct	Wednesday 30 Sep	Thursday 02 Jul
	Friday 02 Oct	Thursday 01 Oct	Friday 03 Jul
	Monday 05 Oct	Sunday 04 Oct	Monday 06 Jul
	Tuesday 06 Oct	Monday 05 Oct	Tuesday 07 Jul
	Wednesday 07 Oct	Tuesday 06 Oct	Wednesday 08 Jul
	Thursday 08 Oct	Wednesday 07 Oct	Thursday 09 Jul
	Friday 09 Oct	Thursday 08 Oct	Friday 10 Jul
	Monday 12 Oct	Sunday 11 Oct	Monday 13 Jul
	Tuesday 13 Oct	Monday 12 Oct	Tuesday 14 Jul
	Wednesday 14 Oct	Tuesday 13 Oct	Wednesday 15 Jul
	Thursday 15 Oct	Wednesday 14 Oct	Thursday 16 Jul
	Friday 16 Oct	Thursday 15 Oct	Friday 17 Jul
	Monday 19 Oct	Sunday 18 Oct	Monday 20 Jul
	Tuesday 20 Oct	Monday 19 Oct	Tuesday 21 Jul
	Wednesday 21 Oct	Tuesday 20 Oct	Wednesday 22 Jul
	Thursday 22 Oct	Wednesday 21 Oct	Thursday 23 Jul
	Friday 23 Oct	Thursday 22 Oct	Friday 24 Jul
	Monday 26 Oct	Sunday 25 Oct	Monday 27 Jul
	Tuesday 27 Oct	Monday 26 Oct	Tuesday 28 Jul
	Wednesday 28 Oct	Tuesday 27 Oct	Wednesday 29 Jul
	Thursday 29 Oct	Wednesday 28 Oct	Thursday 30 Jul
	Friday 30 Oct	Thursday 29 Oct	Friday 31 Jul
November	Monday 02 Nov	Sunday 01 Nov	Monday 03 Aug
	Tuesday 03 Nov	Monday 02 Nov	Tuesday 04 Aug
	Wednesday 04 Nov	Tuesday 03 Nov	Wednesday 05 Aug
	Thursday 05 Nov	Wednesday 04 Nov	Thursday 06 Aug
	Friday 06 Nov	Thursday 05 Nov	Friday 07 Aug
	Monday 09 Nov	Sunday 08 Nov	Monday 10 Aug
	Tuesday 10 Nov	Monday 09 Nov	Tuesday 11 Aug
	Wednesday 11 Nov	Tuesday 10 Nov	Wednesday 12 Aug
	Thursday 12 Nov	Wednesday 11 Nov	Thursday 13 Aug
	Friday 13 Nov	Thursday 12 Nov	Friday 14 Aug
	Monday 16 Nov	Sunday 15 Nov	Monday 17 Aug
	Tuesday 17 Nov	Monday 16 Nov	Tuesday 18 Aug
	Wednesday 18 Nov	Tuesday 17 Nov	Wednesday 19 Aug
	Thursday 19 Nov	Wednesday 18 Nov	Thursday 20 Aug
	Friday 20 Nov	Thursday 19 Nov	Friday 21 Aug
	Monday 23 Nov	Sunday 22 Nov	Monday 24 Aug
	Tuesday 24 Nov	Monday 23 Nov	Tuesday 25 Aug
	Wednesday 25 Nov	Tuesday 24 Nov	Wednesday 26 Aug
	Thursday 26 Nov	Wednesday 25 Nov	Thursday 27 Aug
	Friday 27 Nov	Thursday 26 Nov	Friday 28 Aug
	Monday 30 Nov	Sunday 29 Nov	Monday 31 Aug
December	Tuesday 01 Dec	Monday 30 Nov	Tuesday 01 Sep
	Wednesday 02 Dec	Tuesday 01 Dec	Wednesday 02 Sep
	Thursday 03 Dec	Wednesday 02 Dec	Thursday 03 Sep
	Friday 04 Dec	Thursday 03 Dec	Friday 04 Sep
	Monday 07 Dec	Sunday 06 Dec	Monday 07 Sep
	Tuesday 08 Dec	Monday 07 Dec	Tuesday 08 Sep
	Wednesday 09 Dec	Tuesday 08 Dec	Wednesday 09 Sep
	Thursday 10 Dec	Wednesday 09 Dec	Thursday 10 Sep
	Friday 11 Dec	Thursday 10 Dec	Friday 11 Sep
	Monday 14 Dec	Sunday 13 Dec	Monday 14 Sep
	Tuesday 15 Dec	Monday 14 Dec	Tuesday 15 Sep
	Wednesday 16 Dec	Tuesday 15 Dec	Wednesday 16 Sep
	Thursday 17 Dec	Wednesday 16 Dec	Thursday 17 Sep
	Friday 18 Dec	Thursday 17 Dec	Friday 18 Sep
	Monday 21 Dec	Sunday 20 Dec	Monday 21 Sep
	Tuesday 22 Dec	Monday 21 Dec	Tuesday 22 Sep
	Wednesday 23 Dec	Tuesday 22 Dec	Wednesday 23 Sep
	Thursday 24 Dec	Wednesday 23 Dec	Thursday 24 Sep
	Friday 25 Dec	Thursday 24 Dec	Friday 25 Sep
	Monday 28 Dec	Sunday 27 Dec	Monday 28 Sep
	Tuesday 29 Dec	Monday 28 Dec	Tuesday 29 Sep
	Wednesday 30 Dec	Tuesday 29 Dec	Wednesday 30 Sep
	Thursday 31 Dec	Wednesday 30 Dec	Thursday 01 Oct

APPENDIX 6 - SURVEY EVALUATION CHECKLIST

Please make out a separate questionnaire for each interview you conduct. For all "Yes" answers, please specify the *question numbers* and *explain* what the situation or problem seemed to be. Please indicate how the survey was administered by ticking the appropriate box.

Ã entirely self-completed Ã completed by the client with some verbal assistance Ã read out loud to the client.

	Yes	***No***	***Not Applicable***
1. Did any of the questions seem to make the client uncomfortable? Details:	Ã	Ã	Ã
2. Did you have to repeat any questions? Details:	Ã	Ã	Ã
3. Did the client misinterpret any questions? Details:	Ã	Ã	Ã
4. Did any of the questions contain words or concepts that were not easily or consistently understood by clients? Details:	Ã	Ã	Ã
5. Which questions were the most difficult or awkward for you to read? Have you come to dislike any questions? Why? Details:	Ã	Ã	Ã
6. Did any of the questions seem to drag? Details:	Ã	Ã	Ã
7. Were any of the answers given by the client contradicted elsewhere or at some later point? Details:	Ã	Ã	Ã

Based on the pre-test checklist in Converse & Presser 1986, p.73 and figure 5.4 in Fowler 1995, p.122.

APPENDIX 7 - COUNSELLOR HANDBOOK & DIARY

LDQ Project Counsellor's Handbook & Diary

Counsellor: _____

Work Site: _____

FOR ALL PROJECT SUPPORT CONTACT:

Stuart MacKinnon
Clinical Researcher

Auckland Regional Alcohol & Drug Services
Level 1, Toshiba House,
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Grafton,
Auckland.

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Fax: 377-7399

stuart@rads.co.nz

The RADS Research Unit and your manager congratulate you on your decision to become part of the Leeds research project team.

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In doing so, you have the opportunity to expand your existing skill base by being:

a) Among the first New Zealand counsellors to have learned and used the *Timeline Follow Back* method of alcohol assessment developed by Sobell and Sobell and,

b) involved in RADS largest externally funded research project.

The purpose of the project is to assess the clinical utility of the Leeds Dependence Questionnaire among different ethnic groups in the New Zealand context.

A byproduct of the project is that it allows us the opportunity to trial some new tools in the assessment of alcohol dependence within our own service. Project team members will provide valuable input into the ongoing development of our own clinical procedures.

Contents

Who to Include

As a member of the Leeds Research team, you will be making decisions about who to invite to take part in the project.
Participants must be:

1. Experiencing problems with with alcohol (with or without other drugs).
2. Fluent English speakers.
3. Thought to be capable of attending the assessment interview in a non-intoxicated state.
4. Must not be suffering any severe illness or disability (physical or psychological) which is likely to interfere with their ability to complete the interview.

(See the middle page of this booklet for a flowchart describing your entire involvement with each client).

The LDQ (Client) Interview Booklet

The *Leeds Dependence Questionnaire Booklet* contains all the materials you need to record interview information. Simply start at page one and work through the booklet with your client.
The booklet contains the following material in order
Counsellor assists

- Participant Consent Form

Self-completed

- Leeds Dependence Questionnaire
- Severity of Alcohol Dependence Questionnaire
- SF-36 Health Survey
- Social Problem Questionnaire

Counsellor assists

- Timeline Followback alcohol use assessment
- Discussion page - client's LDQ score
- Final questions to client re: experience of the LDQ

Counsellor's use only

- 90-day date table for use with Timeline Followback (back page)

Timeline Follow Back - General Information

The *Timeline Follow Back* (TLFB) technique is well established as the method of choice when obtaining accurate estimates of alcohol and drug use over time.

In this project we will only be using the TLFB to assess alcohol use. The client simply records, the number of standard drinks they have had on each day within the assessment 'window' on the calendar provided. This information is then entered into a computer program and a range of useful information can then be feed back to clients For example:

- A summary of the average number of drinks consumed by month, days of the week, and weekdays verses weekends.
- Estimated financial cost of drinking over the last year.
- Additional calories consumed per drinking day.
- Longest periods of abstinence during the assessment 'window'.
- Longest number of continuos drinking days during the assessment "window".
- Graphs which assist the client to form impressions of their drinking patterns.

In the Leeds Project we are asking clients to recall, *as best they can*, the number of drinks they have consumed over the last 90 days. Ninety days is the recommended 'window' when using the TLFB in clinical settings how-ever for research purposes it has been used successfully to assess substance use as far back as 12 months.

Timeline Follow Back – Required Accuracy

Remember, the aim of the TLFB method is to obtain approximate information. As the TLFB manual says…

"It is important for both interviewers and respondents to remember that the TLFB method is a retrospective procedure and, as such, requires people to provide their best estimates of their past drinking. Some amount of error in reports is to be expected (Sobell and Sobell, 1992)[8]. In most cases this will not affect the clinical utility of the TLFB information, for the amount and frequency of drinking will still be relatively accurate. For example for clinical purposes, it makes little difference if a heavy drinking day involved 17 or 20 standard drinks or if it occurred on January 17 or January 18. The important point is that the TLFB will provide a reasonably accurate summary of the major features of a person's drinking: amount, frequency, pattern, and degree of variability. While all retrospective measures of drinking by their nature will result in some degree of error (Hammersley, 1994)[9], the TLFB as compared with other measures has been shown to provide a more precise and accurate picture of peoples drinking (Sobell and Sobell, 1992)[1]" (p. 42)."

Timeline Follow Back – Quick Tips

TLFB Tips and Techniques to Aid Recall (From p.31-33 of the Manual)

Drinking boundaries:

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8 Sobell, L.C. & Sobell, M.B. (1992). Timeline Follow-back: A technique for assessing self reported alcohol consumption. In R.Z. Litten and J. Allen (Eds.) *Measuring alcohol consumption: Psychosocial and biological methods.* (pp. 41-72). New Jersey: Humana Press.

9 Hammersley, R. (1994). A digest of memory phenomenon for addiction research. *Addiction, 89,* 23 -41.

A drinking boundary procedure establishes upper and lower drinking amounts for the time period under consideration. When starting the interview, the interviewer asks about the greatest and the least amounts consumed on any day in the reporting period. Asking the greatest amount gives the respondent permission to report high levels of consumption.

Daily Calendar:

The daily calendar provides a prompt for recalling events and patterns related to drinking. Some respondents have found it useful to consult their appointment or date books as aids in completing the calendar.

Key Dates:

NZ holidays are already marked on the calendar. Encourage the client to mark as many personally important dates as possible (e.g. birthdays, weddings, sports events, arrests, arguments etc. Such events provide 'anchor' points and help prompt memories of concurrent drinking events as a result.

Black & White Days:

Using this procedure, respondents are asked to recall lengthy periods of time when they completely abstained (i.e. white days), drank in a very patterned manner (e.g., 10 drinks every day; one or two drinks every Wednesday; eight beers routinely on Fridays and Saturdays) or drank heavily for an extended time period (i.e. Black Days).

Exaggeration Techniques:

For example, if a client reports having drunk "a lot" of beers on a day, but claims an inability to specify what "a lot" means, the interviewer can ask the respondent "Does 'a lot' mean two beers or 30 beers?" A typical response to this question might take the form of "certainly not 30 beers, more like 12 to 14. Beers. (*Stuart's Note*: the client should then enter "13" as the average of the two figures).

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	
Client Number:	
J **Positive Observations of the LDQ:**	
L **Negative Observations of the LDQ:**	
K **General Comments:**	

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	
Client Number:	
J **Positive Observations of the LDQ:**	
L **Negative Observations of the LDQ:**	
K **General Comments:**	

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	
Client Number:	
J **Positive Observations of the LDQ:**	
L **Negative Observations of the LDQ:**	
K **General Comments:**	

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	
Client Number:	
J **Positive Observations of the LDQ:**	
L **Negative Observations of the LDQ:**	
K **General Comments:**	

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	

Client Number:	
J **Positive Observations of the LDQ:**	
L **Negative Observations of the LDQ:**	
K **General Comments:**	

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	
Client Number:	

J **Positive Observations of the LDQ:**	
L **Negative Observations of the LDQ:**	
K **General Comments:**	

Counsellor's Diary

(*Do not record client names on this page*)

Interview Date:	
Client Number:	

J

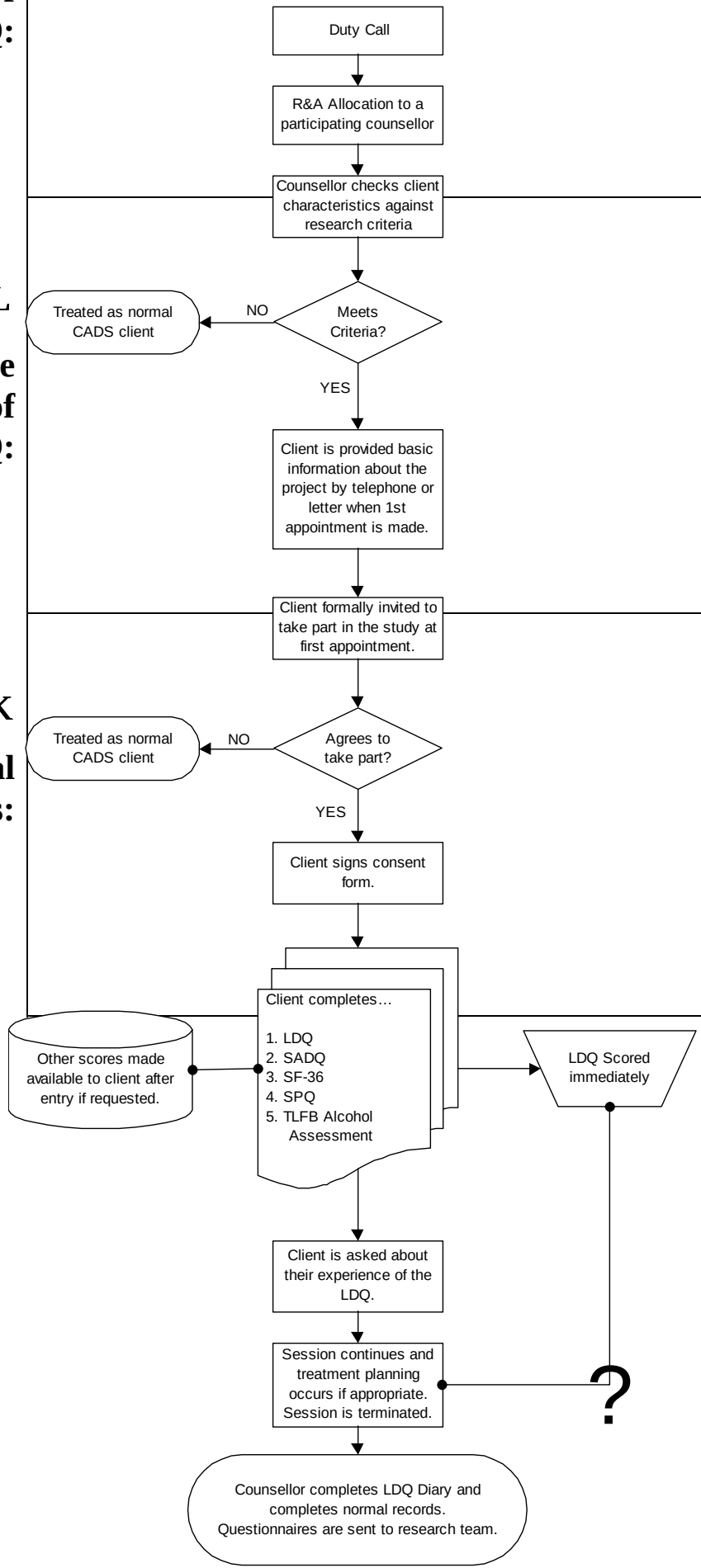
Positive Observations of the LDQ:

L

Negative Observations of the LDQ:

K

General Comments:



APPENDIX 8 - FOCUS GROUP INTERVIEW QUESTIONS

Introduction:

This is the beginning of the "focus group interview" we have invited you here for. Thanks for setting aside the time to attend.

The main purpose of the interview is to find out about how the Leeds assessment package, and the LDQ were used in assessment and treatment planning.

[INTRODUCE PROPS]

We would like to hear about negative experiences and opinions as well as positive ones. Please feel free to say what you think even if it differs from what others have said.

The interview is confidential insofar as no counsellor names or unit names will be used in any research reports written about the project.

The interview will be recorded because we are interested in the detail of what people have to say. The only other person who will have access to the tape will be an admin assistant who will type up the transcript.

Please speak up and try not to talk over anyone else because the tape will get garbled and we'll miss what you are saying.

We are going to start with a quick round just to break the ice, where everyone will have a chance to say what their current role is.

Questions:

1: Warm-up question

(Short answer round): "In thirty seconds or less, please tell everyone what your current role is."

2: Introductory questions:

a. How did you first hear about the Leeds Project.
b. (OPTIONAL) How did you expect the project to affect you?

3: Transition Questions:

a. How did clients react to being offered the opportunity to take part in the research?
b. What sort of approaches did you use to get clients interested?

4: Key Questions:
Thinking about assessments you did using the Leeds Assessment Package…
How did clients react to the: (a) assessment package as a whole?
(b) the LDQ in particular..

5: Key Questions:
a. Where there any difficulties incorporating the Leeds Assessment Package into the assessment?
b. How did you deal with any difficulties?

6: Key Questions:
a. How did the Leeds assessment package (as a whole) contribute to your assessments?
b. How did the LDQ contribute to your assessments?
c. How did different clients respond to their LDQ result/score?

7: Key Questions:
a. How did the Leeds assessment package (as a whole) contribute to your Treatment Planning?
b. How did the LDQ contribute to your Treatment Planning?
c. Did you do anything differently with clients as a result of the LDQ?

8: "All things considered" Question:
a. All things considered, how useful do you think the LDQ (on its own) is for treatment planning and assessment?
b. For those of you who saw Maori or Pacific Nations clients, all things considered, how useful do you think the LDQ (on its own) is for treatment planning and assessment with either of these two groups.

9: Maori and Pacific Nations Clients Question:
For those of you who saw Maori and Pacific Nations Clients…

a. What advice would you give a counsellor who is wanting to use the LDQ with Maori or Pacific Nations clients.
b. What advice would you give if the counsellor is from a different culture than the client?

10: Key Question (Throw away)
Is anyone here still using all or part of the Leeds Assessment package during their assessments?

<2-3 minute interview summary provided to interviewees by one of the interviewers.>

11: Closing Question:
Is this an adequate summary?

12: Closing Question:
Have we missed anything? Is there anything else we should take note of?