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# **Drug System Change Pilots Evaluation**

## **Final Report**

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## Glossary

<b>ACT</b>	Acceptance and Commitment Therapy
<b>APTB</b>	Adult pooled treatment budget
<b>BTEI</b>	Birmingham Treatment Effectiveness Initiative
<b>CA</b>	Cocaine Anonymous
<b>CARAT</b>	Counselling, Assessment, Referral, Advice and Throughcare service
<b>CEST</b>	Client Evaluation of Self and Treatment
<b>CJIT</b>	Criminal Justice Integrated Team
<b>CJS</b>	Criminal Justice System
<b>CRB</b>	Criminal Records Bureau
<b>CSMA</b>	Comprehensive Substance Misuse Assessment
<b>DAT</b>	Drug Action Team
<b>DAAT</b>	Drug and Alcohol Action Team
<b>DH</b>	Department of Health
<b>DIMIS</b>	Drug Intervention Monitoring Information System
<b>DIP</b>	Drug Interventions Programme
<b>DIR</b>	Drug Interventions Record
<b>DRR</b>	Drug Rehabilitation Requirement
<b>DSCP</b>	Drug System Change Pilots
<b>DTORS</b>	Drug Treatment Outcomes Research Study
<b>DWP</b>	Department for Work and Pensions
<b>ESA</b>	Employment and Support Allowance
<b>ETE</b>	Education, Training and Employment
<b>HMP</b>	Her Majesty's Prison
<b>IDTS</b>	Integrated Drug Treatment System
<b>IOM</b>	Integrated Offender Management
<b>ITEP</b>	International Treatment Effectiveness Programme
<b>JCP</b>	JobCentre Plus
<b>JSA</b>	Job Seekers Allowance
<b>KPI</b>	Key Performance Indicator
<b>KPT</b>	Key Performance Target
<b>LASARS</b>	Local Area Single Assessment and Referral System (LASARS)
<b>NDTMS</b>	National Drug Treatment Monitoring System

<b>NA</b>	Narcotics Anonymous
<b>NatCen</b>	NatCen Social Research
<b>NHS</b>	National Health Service
<b>NOMS</b>	National Offender Management Service
<b>NTA</b>	National Treatment Agency for Substance Misuse
<b>OCU</b>	Opiate / Crack User
<b>ORC</b>	Organisation Readiness to Change
<b>PbR</b>	Payment by Results
<b>PCT</b>	Primary Care Trust
<b>PDU</b>	Problematic Drug User
<b>PTB</b>	Pooled Treatment Budget
<b>RAS</b>	Resource Allocation System
<b>SHA</b>	Strategic Health Authority
<b>SDP</b>	Short Duration Programme
<b>SDS</b>	Self-Directed Support
<b>TOP</b>	Treatment Outcome Profile
<b>TUPE</b>	Transfer of Undertakings (Protection of Employment)
<b>VfM</b>	Value for Money

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## Executive summary

The Drug System Change Pilots (DSCPs) were set up to test the potential to improve the way that drug treatment and related social provision were delivered by adopting more user-led, outcome-focused approaches at a regional and local level, both in prison and the community. The pilot sites were given the opportunity to test a variety of approaches during a two year period by using funding flexibilities and thinking innovatively about the commissioning, delivery and implementation of services within their region. A key element of the pilot was local innovation so the programme did not prescribe a detailed change pathway. Local areas were invited to bid for DSCP status and seven partnerships<sup>1</sup> were selected as DSCPs.

During the course of the two year pilot (April 2009 to March 2011), the Coalition Government came to power and in December 2010 the drug strategy “Reducing demand, restricting supply, building recovery” was published, outlining a commitment to localism and greater autonomy for local drug treatment systems. With their focus on local innovation the DSCPs continue to fit well with this strategy and their experiences provide valuable learning as local areas are given greater autonomy to develop their own drug treatment systems.

In 2009, a collaboration led by NatCen Social Research was commissioned to evaluate the seven pilots. This report presents the findings of the evaluation.

### Methods

- The study comprised three components:
  - *Qualitative case studies* involving in-depth interviews and focus group discussions with staff and service users across the seven pilot areas. These case studies were longitudinal in design, with data collected at the start, mid-point, and end of the pilot period.
  - *Quantitative appraisal* with the aim of measuring the impact of the DSCPs on service users and their outcomes. Existing administrative data was used for the analysis and the impacts of the DSCPs were examined in relation to continuity of care, and proportions of service users in effective treatment and successfully completing treatment.
  - *An economic evaluation* was conducted to assess the benefits delivered by the DSCPs relative to the resource costs of bringing them about.

### Key findings

#### Structural changes

- Pilots took three broad approaches to changing their treatment system structures: single provider systems; consortium based systems; and improving partnership arrangements.
- Within *single provider treatment systems* funds were pooled and a single provider commissioned to deliver an integrated criminal justice treatment system. The

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<sup>1</sup> These were the Safer Essex Partnership Board, Hampshire Partnership Trust, Leicester City DAAT, Safer Lambeth Partnership, Hertfordshire DAAT, Bradford Safer Communities Partnership and Sefton DAT.

strengths of this approach were thought to be that a single provider could streamline processes, improve continuity of care and create a coherent treatment system, through a coherent management and governance structure. Challenges in implementing a model of this kind included streamlining and pooling commissioning budgets, reconfiguring existing targets and developing performance management structures that supported a single provider approach.

- An alternative was the *consortium based approach*. As with the single provider approach, the aim was to improve coherence across the treatment system, continuity of care and efficiency. In two areas these arrangements were seen as a precursor to creating a single provider integrated treatment system, while in one, the consortium arrangement was viewed as a way of promoting increased partnership working and coherence, whilst maintaining the diversity of provision. Consortium based approaches were characterised by regular partnership meetings, and partnership working agreements that enshrined shared objectives and system-wide performance management structures. Challenges in implementing a model of this kind echoed those found in the single provider model. Additional challenges included the complexity of creating coherent treatment systems while individual contracts continued to operate, and ensuring consortium partners could be held to account for the coherence of the treatment system as a whole, without the legal framework of a single commissioned service.
- The final approach to creating more coherent treatment systems involved measures to improve *partnership working* without commissioning a single provider service or formalising partnerships within a consortium arrangement. This approach was characterised by regular provider meetings, and workforce development that fostered shared training and role-shadowing across the treatment system to promote improved communication and partnership working. Working groups were developed in one area to improve partnership working between drug treatment services and mainstream service providers, with the aim of reducing duplication and improving provision within mainstream settings. Challenges in maintaining partnership arrangements of this kind centred on risks to sustaining partnerships without formal agreements and structures to facilitate them, and the danger that informal arrangements were more vulnerable to retrenchment in times of economic austerity.

#### **System changes: continuity of care**

- Tackling continuity of care within the treatment system, to improve treatment experiences for service users and ultimately improve treatment outcomes, was identified as a primary goal for a number of pilot areas. Four broad approaches to tackling continuity of care were adopted.
- *Integrated community criminal justice system (CJS) and prison drug treatment teams*, with a single governance structure and integrated performance management, were designed to promote seamless continuity of care. Key features of this approach included measures to improve communication via integrated IT systems, reconfigured “whole system” performance management frameworks, and efforts to streamline referral, assessment and care planning paperwork. Pilots also explored different approaches to case management. Integrated systems of this kind were thought to have strong potential to improve service user treatment experiences by reducing duplication in assessment, promoting more seamless treatment and improving communication across the system. Analysis of administrative data on the impact of integrated teams on continuity of care was largely inconclusive, although a positive impact was found in one pilot area. Features of the integrated service in this area included prison read-only access to the community case management system,

a single performance monitoring framework and a streamlined referral and assessment process, indicating that these may be successful features of integrated teams.

- The *independent case manager* approach promoted continuity of care by providing continuous case management across the criminal justice treatment pathway via an independent case manager, supporting the service user and acting as an independent broker of services to promote a seamless treatment experience. A strength of this approach was the perceived ability of the independent case manager to take a person-focused approach and to support service users in accessing a wide range of both mainstream and drug treatment services, without being tied to existing targets and structures. Analysis of administrative data showed that in the pilot area adopting this approach continuity of care improved during the pilot period. However, caution must be taken in attributing this improvement solely to the independent case manager role as it operated on a small scale and other elements of pilot activity may also have contributed to the improvement. Post-pilot the approach is being rolled out and will be delivered by a larger team.
- *Embedding CJS teams within community drug treatment services* aimed to facilitate transitions from criminal justice pathways into community drug treatment. Simultaneously, Drug Interventions Programme (DIP) and Drug Rehabilitation Requirement (DRR) funding was combined to ensure a consistent range of provision was available to service users regardless of whether they were subject to a DRR order or accessing DIP provision. A strength of this approach was thought to be improved communication across the treatment system and a greater awareness amongst service users of the range of community provision available. By embedding DIP provision within community treatment services, the pilot area was also able to improve the geographical spread of their provision, improving access to local services. Analysis of administrative data showed that the number of referrals made from the community-based CJITs into the broader treatment system rose during the pilot, suggesting embedding the CJS team into community provision improved referrals. Where the impact becomes less clear is that the number of these referrals successfully triaged within six weeks fell during the pilot period, suggesting that perhaps the increase in referrals strained service capacity to meet the increased level of demand.
- The final approach to improving continuity of care via *linking roles* involved targeting the point in the treatment journey between custody and the community where services historically failed to join up and service users were at risk of disengaging. One model for this form of support involved contracting a third sector organisation to provide “through the gate” support on release from custody and ongoing support within the community. Another pilot area embedded a team of staff within their community criminal justice treatment teams, with the specific role of ensuring continuity across the system. This type of provision was often used in conjunction with other measures to improve continuity of care already discussed. A key strength of this approach was that it provided support at the most vulnerable points in a service user’s treatment journey. Strong communication across the treatment system was considered critical to the success of this approach, to ensure that staff were equipped with up to date information on prison movements and transfers.

### **System changes: personalisation**

- In creating more personalised treatment systems, pilots were seeking to improve treatment outcomes by ensuring that services were tailored to the needs of individual service users. Two broad approaches to tackling personalisation were adopted.
- *Self-directed support (SDS)* represents a new way of working that gives service users greater choice and control over their treatment and support, so the best possible outcomes can be achieved for each individual. SDS was implemented in two of the pilot sites and both utilised pilot funding to pay for new services not currently commissioned within their block contracts. Within this model, service users were assessed and allocated a budget which they then used to “purchase” services to meet their treatment needs. This highly personalised approach was felt to improve engagement in treatment and foster a sense of self-efficacy and responsibility for their own treatment amongst service users. Challenges in delivering SDS included communicating the value and purpose of the approach effectively to service users and staff; tackling the complexity of brokering a wide range of personalised provision; and reconfiguring provision to accommodate this different approach to service delivery. Delays in accessing services as a result of this complexity were a particular concern as this was felt to be jeopardise service user engagement with treatment. The SDS pilots were too small to assess quantitative impact, however staff and service users identified positive impacts on drug use, health, self-efficacy and relationships with family and the wider community. The personalised approach of SDS was also felt to increase the treatment system’s focus on outcomes and encouraged greater use of mainstream provision.
- One pilot area sought to create a more personalised treatment system by developing a *single point of assessment (SPA)* designed to provide service users with an independent comprehensive assessment. The purpose of this was to ensure that all the needs of the service user were addressed and that they were referred to a wide range of appropriate drug treatment provision and mainstream services. A key strength of this approach was thought to be the independence of the SPA assessment staff who were not allied to any single provider so consequently referred service users to a broad spectrum of drug treatment and mainstream services. Contact with the SPA was also not limited to one assessment; and service users could be re-referred or refer themselves back to the SPA at any point during their treatment or on completion. Service users valued the impartiality of the SPA and the co-location of other services including mentors, and education, training and employment (ETE) and housing advisors.

Staff also identified positive impacts including greater diversity in the range of service users seeking treatment, increased referrals from a range of agencies including GPs, and improved access to ETE due to referrals from the SPA and co-location of representatives from ETE services in the SPA building. Alongside these positive impacts staff also identified challenges, including the potential for delays in accessing treatment if the SPA experienced high demand, and ensuring that the broad range of referrals made by the SPA were followed up and dealt with effectively. In the site piloting this approach a positive impact was found on the proportion of service users in effective treatment. This suggests that the SPA may have had a positive impact, although other elements of pilot activity may have also contributed to this change. In terms of levels of successful treatment completions, the data indicated a positive trend, but was not found to be statistically significant.

## Delivery changes

- Alongside structural and system change, sites took the opportunity presented by system change pilots to re-orient their treatment provision towards a greater focus on recovery and reintegration.
- A primary goal of system change was to promote recovery and re-integration, and so several pilot areas took the opportunity to develop *service user mentoring* provision. The aim was to support current service users accessing treatment while simultaneously providing a stepping stone towards recovery and reintegration for those taking on the service user mentor role. Impacts identified for mentors were increased self-esteem, confidence and employability. For service users, mentors were felt to encourage engagement and provide positive role models. Key features of effective mentor programmes were identified as good quality training and development, ongoing support and supervision, risk management procedures, ongoing communication to staff and service users, and senior stakeholder engagement to champion the approach.
- To improve the quality of assessment and care planning, a number of pilot areas rolled out training on *ITEP/BTEI mapping methods* and introduced these methods into their assessment and care planning tools. Delivery staff and service users spoke positively about the use of these techniques, describing them as more interactive and service user-led. In addition, evaluation tools designed to improve organisational self-evaluation and monitoring were used and supported providers to critically evaluate their own practice and take responsibility for the quality of the services they were providing.
- A number of areas explored *family therapy or family group conferencing* as part of their pilot. The aim of introducing support of this kind was to address the needs of the whole family and in doing so, support the service user in their recovery. A particular focus within the pilots was providing this form of support within a prison setting. Two distinct models were adopted – single episode family group conferencing and systemic family therapy over multiple sessions. Pilots of this kind of support were typically small in scale reflecting their relatively high cost. A key challenge therefore was sustaining this provision post-pilot. In one area the service was discontinued because the cost was unsustainable, while another sought to embed group conferencing into its post-pilot provision through a service level agreement with a partner agency.
- *Access to ETE* was widely regarded as an essential element of recovery and it was within this context that pilot areas introduced initiatives to incorporate ETE provision into their pilots. The range of initiatives introduced included building relationships with Welfare to Work providers; working with employers to dispel common misconceptions about substance misuse; providing ETE mentors; creating a directory of existing ETE provision to make better use of existing services; training staff to increase their awareness of ETE services and using SDS to enable service users to identify and address their own training needs.

Staff found it challenging to identify the impacts of ETE pilot activity on service users, due to the challenging economic climate and monitoring data on employment that was not always felt to be reliable. Budget cuts both locally and nationally (during and post-pilot) were identified as barriers to developments in this area, particularly in cases where partnership arrangements had been established between JobCentre Plus (JCP) and local treatment services, as there was concern that budget retrenchment would reduce capacity for this form of working.

- *Stable housing* was identified by service users as crucial to their recovery, with housing crisis identified as a trigger for relapse. Measures piloted included training case managers to provide housing advice; co-locating local authority housing staff within a SPA to improve access to advice and support; employing a dedicated housing officer to work with service users; putting in place measures to provide emergency bed and breakfast accommodation for those released from custody; and supporting service users to access mainstream services by providing advocacy.

From service user interviews positive impacts of housing support included help with addressing rent arrears and finding accommodation on release from custody. Despite some positive experiences of accessing housing support, service users continued to identify housing concerns as a risk to recovery. While work was being done with these service users to address these needs, difficulties in accessing appropriate accommodation continued to be a challenge across the pilot areas.

- To support the creation of active recovery communities, some pilots fostered the development of *mutual aid groups*. Methods adopted included supporting service users to set up their own groups by providing premises and budgets for room hire and refreshments. Pilot areas spoke of the importance of ensuring treatment staff had a good understanding of the range of different mutual aid groups available and were equipped with the knowledge to refer service users appropriately. Peer mentors were also felt to play a role in raising awareness of mutual aid support. Some stakeholders raised that mutual aid referrals were not recorded on the National Drug Treatment Monitoring System (NDTMS). It was felt that targets and the way in which activities were recorded on NDTMS needed to be revisited to avoid disincentives to providing support of this kind.

### **Impacts: effective treatment and successful completions**

- Administrative data on the proportion of service users in effective treatment and the proportion of service users successfully completing treatment was analysed in order to evaluate the impact of the DSCPs. The choice of outcome indicators was constrained by the administrative data available, and the ability to detect impact and attribute it to particular elements of pilot activity was limited by the complexity of the pilots. The timescales of the evaluation also limited the extent to which long-term impacts could be detected. It is important to take account of these factors when interpreting the findings on proportions in effective treatment and successful treatment completions. One pilot area exploring SDS was also excluded from this analysis because the numbers involved in the pilot were too small.
- Two pilot areas (sites 3 and 7) were defined as “*whole system*” pilots, reflecting their intention to affect change across the whole treatment system. In these pilots the evaluation found a positive impact in relation to proportions in effective treatment with a ‘difference in difference’ when compared to their comparison areas of +3.6 and +2.8 percentage points which was found to be statistically significant<sup>2</sup>. These results suggest that both whole system pilots may have helped to increase the proportion of service users in effective treatment. In terms of the proportion of successful treatment completions, the results were more mixed. Site 3 showed a positive trend while site 7 showed a negative trend. However in both cases, the change was not statistically significant and so neither pilot can be shown to have had a measurable effect on successful completions. However, caution should be taken when judging pilot activity

<sup>2</sup> See Appendix B for a full description of the quantitative analysis methodology and an explanation of the ‘difference in difference’ approach.

on this measure as the full impact of pilot activity on successful completions is unlikely to be felt until some time after the pilots have ended.

- Four of the seven pilot areas (sites 2, 4, 5 and 6) were “*criminal justice*” pilots, meaning their focus was on improving drug treatment provision for service users within the criminal justice system exclusively. Because these sites were attempting to impact on a sub-sample of their wider treatment population, it could be expected that the impact on numbers in effective treatment and levels of successful completions within the wider cohort might be lower. Analysis of data on proportions in effective treatment revealed a negative trend when compared to their comparison areas which was statistically significant in three areas (sites 2, 5 and 6). This is perhaps unsurprising as pilot activity may be expected to cause some disruption at least in the short term; longer term follow-up may be required to determine whether these trends persist.

In terms of successful completions the picture was mixed, with no measurable impact in three areas and a negative impact in site 6. In interpreting these results, it is important to remember that these pilots focused their activity on their criminal justice treatment systems, with particular attention paid to continuity of care between prison and community treatment provision. It would be reasonable to expect a time lag before improvements to continuity of care filter through to improvements in service user outcomes. A re-examination of these indicators two to three years after the pilot would be a valuable exercise to explore further the full impacts of DSC.

## Conclusion

- The freedoms and flexibilities offered within the pilot were important in changing treatment systems. However, freedom and flexibilities were not always sufficient on their own to affect change, nor were they always a necessary foundation to reconfiguring treatment systems at a local level. Indeed, the active engagement and commitment of the treatment providers and partner agencies was thought to be as important an element of pilot success as the use of freedoms and flexibilities. With increased freedom at a local level to design drug treatment systems, there was potential for differences between localities to be exacerbated rather than reduced. In tackling continuity of care and ensuring coherent treatment systems that maximise outcomes for service users, attention must also be paid to coherence *between* localities as well as within them.
- Given the importance of partnership working in affecting change, a key challenge for areas seeking to learn from the DSCPs, will be how to achieve this level of partner engagement and co-operation without pilot status. A commissioning and funding framework that incentivises co-operation will be crucial if local areas are to be successful in developing coherent and innovative treatment systems. The Drug and Alcohol Recovery Payment by Results (PbR) pilots represent an ideal opportunity to explore these issues.
- The DSCPs have provided valuable learning in relation to tackling continuity of care. Pooled budgets, partnership arrangements and system-wide performance monitoring were viewed as important foundations to achieving continuity of care as were strong leadership and work force development. A key barrier remained fragmented communication across the treatment pathway. Whether a solution can be found to this issue will be critical to improving continuity of care in the future.
- Lessons can be drawn from pilot activity that tailored provision to the individual needs of service users. In particular, the SPA is similar in design and ethos to the Local

Area Single Assessment and Referral System (LASARS) currently being developed as part of the PbR pilots. Facilitators to effective SPA delivery included independence from existing treatment providers; a central location for easy access; clearly defined referral routes; adequate levels of staffing with high quality training; and careful consideration given to onward referral routes.

- Because SDS was piloted on a small scale, it is difficult to assess the impact of this approach if rolled out more widely. It was beyond the scope of these pilots to put in place the contracting mechanisms that would be needed to operate a drug treatment system funded by SDS or to test elements of SDS like “buyer groups” because numbers were too small. There was some feedback from sites that this form of support was most effective for service users reaching the end of their treatment journey as a way of supporting and sustaining recovery. The role SDS can play in aftercare and sustaining long-term recovery may be a fruitful area for further investigation.
- Changes to delivery included implementing service user mentors, ITEP mapping, family therapy, ETE provision, housing services and mutual aid groups. Small in scale and delivered alongside other elements of pilot activity, it is difficult to assess the value and impact of these changes to pilot delivery. Further systematic evaluation and large scale piloting is required to explore their impact more fully.
- From an economic perspective, the value of the benefits (in the form of improved outcomes for sites) relative to the costs of implementing the programme was critical. The benefits were estimated as the product of the number of clients at a site with improved outcomes, taking account of any changes that might have been expected on the basis of changes in the comparison sites. The two outcome measures used were the number of clients in effective treatment and the number of successful treatment completions. The unit values for an additional client in treatment and for a successful treatment completion were derived from earlier studies, particularly the Drug Treatment Outcomes Research Study (DTORS) (Davies et al., 2009) and the National Treatment Agency (NTA) study (2011) of drug use careers. The 'benefit' findings matched those from the impact findings, since the same estimates from the difference in differences model were used as a starting point. In the one pilot area where impact was positive the benefits were found to be strongly positive. This occurred in large part because the pay-off to each type of outcome is substantial in financial terms. There are, however, substantial caveats in the case of both the estimate of the unit value of a benefit and the estimated impact. Further development of the NTA's Value for Money (VfM) model will be able to shed further light on these findings in due course.
- Assessing the full impact of the DSCPs would benefit from further follow-up to track outcomes over a longer time period.

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# 1 Introduction

This report sets out the findings of the evaluation of the Drug System Change Pilots (DSCPs). This first chapter briefly describes the background to the DSCP and the evaluation design and methodology. It then goes on to discuss the DSCP theory of change, before setting out the structure of the rest of the report.

## 1.1 Background

The DSCPs were set up under the previous government with the aim of piloting new approaches to drug treatment and social integration (HM Government 2008). The intention was to explore whether greater autonomy and flexibility at a local level would encourage innovation and partnership working and so make more effective use of local resources to meet the treatment and support needs of drug users and their communities. The range of outcomes the pilots were designed to achieve included better engagement and retention in treatment, improved continuity of care across the treatment system, improved efficiency in delivering drug services and improved outcomes for service users including improved health, reduced drug use and reductions in criminal behaviour.

Local areas were invited to bid for DSCP status and following a competitive procurement process, in which almost 50 bids were submitted, seven partnerships<sup>3</sup> were selected as DSCPs. In keeping with the ethos of the pilot programme, each of the seven pilots was distinct, with different aims and innovative approaches to tackling system change. The pilots ran from April 2009 to March 2011 and were overseen by a cross-departmental DSCP board. During the course of the two year pilot period, the Coalition Government came to power and in December 2010 the drug strategy “Reducing demand, restricting supply, building recovery” was published, outlining a commitment to localism and greater autonomy for local drug treatment systems. With their focus on local innovation the DSCPs continue to fit well with this strategy and their experiences provide valuable learning as local areas are given greater autonomy to develop their own drug treatment systems.

This report presents the findings of the evaluation, exploring the impact of the DSCPs and the key learning that can be drawn from them.

## 1.2 Evaluation design

In September 2009, a collaboration led by NatCen Social Research was commissioned to evaluate the seven pilots according to the following objectives, to:

- describe the range, scale and nature of activities, key components of system change and outputs of each pilot area;
- develop measures and assess the outcomes and impacts for each pilot area, and for the pilot programme as a whole, including the relationship between project costs and outcomes for each pilot area;

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<sup>3</sup> These were the Safer Essex Partnership Board, Hampshire Partnership Trust, Leicester City DAAT, Safer Lambeth Partnership, Hertfordshire DAAT, Bradford Safer Communities Partnership and Sefton DAT.

- assess the strategic and operational fit of the pilots programme within the local/regional environment and within the wider policy environment;
- identify innovation and good practice, and work with pilot partnerships to share and embed good practice; and
- provide comparisons between pilot partnership areas, and also with some non-pilot partnership areas.

The objectives were met through qualitative, quantitative and economic methodologies, each of which are described below.

## 1.3 Evaluation methodology

### 1.3.1 Component 1: Qualitative case studies

Led by NatCen, the qualitative component used a longitudinal case study design to provide a detailed understanding of the DSCPs. It utilised data drawn from strategic and operational stakeholders and service users, to assess and map the implementation, operation and outcomes of the pilots. The qualitative component comprised three phases, as outlined below.

Firstly, a **scoping implementation** phase (stage one) gathered a strategic overview of early implementation in the pilot areas by mapping activity and obtaining a broad overview of the strategic systems, services and approaches utilised. In doing so, a baseline by which progress may be assessed was set. Next, a **processes and outcomes** phase (stage two) built on the scoping encounters to map the different models of delivery in each area and identify the key successes and challenges encountered. This phase aimed to identify the range of activities taking place, explore what was different about the pilots to what was offered and operated previously, and map the factors influencing the range of early outcomes experienced by treatment system staff and service users. The findings from this stage were shared with the pilot sites and the DSCP Board to provide early feedback and support the pilots going forward. Finally, the **learning and moving forward** phase (stage three) further built on the earlier phases by revisiting pilot sites at the end of the pilot period to identify how pilot activity had developed and changed over time; the extent to which pilot activity was informing plans for the future and to gather views and perspectives of the key learning taken from participation in the pilot programme.

#### Scoping implementation (stage one)

Stage one of the qualitative case studies took place in autumn 2009 and comprised in-depth interviews and desk research. Interviews were conducted with two senior stakeholders in each pilot area. Thirteen interviews were conducted across the seven sites between October and November 2009 (one was a paired interview).

For the desk research, bid documents and action plan updates for each area were reviewed, with their contents summarised and entered into a thematic scoping framework for analysis. The aim of the review was to understand the context of each pilot in relation to its aims, delivery processes and outcomes. This review informed the development of research questions for each pilot site.

## Processes and outcomes (stage two)

The second stage of the qualitative case studies involved interviews and focus groups with stakeholders, delivery staff and service users from all seven pilot areas half way through the pilot period. The aim of these interviews was to:

- identify the aims and objectives of pilot activity;
- map pilot activity in each area;
- explore facilitators and barriers to pilot delivery; and
- explore the nature of anticipated outputs and outcomes for service users, treatment systems, staff and the wider community.

A total of 34 in-depth interviews and 10 focus groups were undertaken with stakeholders, delivery managers and delivery staff across the seven pilot areas. Findings from the baseline report and discussions with pilot areas were used to purposively select stakeholders and staff for interview to gather a wide range of perspectives on pilot activity. Interviews were conducted between June and September 2010 and lasted between 60 and 90 minutes.

In-depth interviews with service users were also conducted. These sought to:

- explore treatment experiences of service users;
- identify how pilot activities differed to service users' previous treatment experiences;
- explore service users' views and perceptions of current treatment options; and
- identify strengths and weaknesses of pilot provision and barriers and facilitators to successful treatment outcomes

A total of thirty face to face in-depth interviews and one paired interview were undertaken with service users across the seven sites. Service users were recruited via their treatment providers. Interviews were conducted between June and October 2010 and each lasted approximately one hour. As a thank you for their time service users received a shopping voucher for a high street retailer.

## Achieved sample at stage two

The achieved sample at stage two of the qualitative evaluation was as follows:

Pilot area	Stakeholders	Delivery staff	Service users	Total
1	4	3	6	13
2	4	2	4	10
3	3	4	5	12
4	4	3	3	10
5	3	3	5	11
6	4	2	4	10
7	4	1	4	9
<b>Total</b>	<b>26</b>	<b>18</b>	<b>31</b>	<b>75</b>

## Learning and moving forward (stage three)

The third and final stage of the qualitative case studies was conducted at the end of the two year pilot period and involved follow-up interviews and focus groups with stakeholders, delivery staff and service users. The aim of these interviews was to:

- reflect on experiences of DSCP as the pilot period came to an end;
- explore progress made;
- explore the nature of impacts, and the facilitators and barriers to these; and
- explore lessons learnt and future plans.

A total of 42 in-depth interviews were undertaken with stakeholders, delivery managers and delivery staff across the seven areas; 35 were conducted over the telephone and seven were face to face. In addition, eight focus groups were held. To capture change over time 38 of the interviews followed up stage two participants. The remaining 12 encounters were with new participants who were purposively sampled to capture elements of pilot activity that had developed since stage two. All interviews were conducted between February and April 2011 and lasted between 60 and 90 minutes.

In-depth interviews with service users were also conducted. These sought to:

- explore the treatment experiences of service users;
- explore change over time for service users as they progressed through their treatment;
- identify the perceived strengths and weaknesses of DSCP activities; and
- explore impacts of treatment provision on service users.

A total of 20 face to face in-depth interviews were carried out with service users across the pilot areas. Seven service users were followed up from stage two to capture impacts of pilot activity over time. Effort was made to re-contact other service users but this proved challenging because their contact details had often changed. In some pilot areas the decision was made to recruit all new participants at stage three in order to capture views on pilot activity that stage two participants had not experienced. Thirteen service users at stage three were therefore new participants. Interviews were conducted between February and April 2011 and lasted approximately one hour each. As a thank you for their time service users again received a shopping voucher for a high street retailer.

The topic guides used in the stage three interviews with staff and service users can be found in Appendix A.

## Achieved sample at stage three

The achieved sample at stage three of the qualitative evaluation was as follows:

Pilot area	Stakeholders	Delivery staff	Service users	Total
1	5	4	3	12
2	4	2	3	9
3	3	3	3	9
4	4	2	3	9
5	3	5	2	10
6	6	2	3	11
7	4	3	3	10
<b>Total</b>	<b>29</b>	<b>21</b>	<b>20</b>	<b>70</b>

### Analysis of qualitative data

All the interviews across stages one, two and three were audio recorded and transcribed. Analysis was undertaken using the Framework method, a qualitative analysis approach developed at NatCen (Ritchie and Lewis, 2003). Verbatim interview quotations are provided in this report to highlight themes and findings where appropriate, with short quotations embedded in the narrative.

### 1.3.2 Component 2: Quantitative appraisal

The aim of the quantitative evaluation was to measure the impact of the DSCPs on service users and their outcomes. It was commissioned with the guidance that existing administrative data should be used with no collection of new primary data in order to minimise burden on the pilot sites. After careful and systematic consideration of the available data sources, two databases were chosen to construct the outcome measures (further discussion of the data sources and indicators selected is given in Appendix B):

- the Drug Interventions Management Information System (DIMIS), a database that holds drug test, assessment and activity data for the Drug Interventions Programme (DIP)<sup>4</sup>; and
- the National Drug Treatment Monitoring System (NDTMS), which gathers information on all episodes of treatment within the community drug treatment sector.

There were three strands to the quantitative analysis:

- data from DIMIS was used to measure continuity of care for clients transferring out of prison to the DIP;
- quarterly DIP to NDTMS reports produced by National Treatment Agency (NTA) analysts were used to measure continuity of care for clients referred by the DIP to community treatment; and
- core data from NDTMS was used to measure effective treatment and successful completions.

<sup>4</sup> The DIP provides interventions for drug-misusing offenders throughout their criminal justice journey.

In each case, the analysis focused on comparing outcomes over two 18 month periods. The DSCPs began on 1st April 2009 and ran until 31st March 2011. The start of pilot activity was delayed as a result of pilot complexity, and so the results discussed here exclude the first six months of the two year pilot period. The timeframes under examination are therefore the 18 month period prior to implementation (1st October 2007-31st March 2009) and the last 18 months of the programme's operation (1st October 2009-31st March 2011).

Six of the seven pilots were included in the quantitative analysis. After discussion with the DSCP Board and the pilot area itself, site 1 was not included because the small number of clients involved in this pilot would have made change very difficult to detect. Each of the remaining pilots was paired with a comparison area which was identified and agreed with the pilot sites. These areas were selected that were as similar as possible on measures that might correlate with the outcomes of interest, including client profile, client caseload, retention rates and funding levels. The analysis therefore compared the change over time in the pilot areas with the equivalent change in the comparison areas. Subtracting one change from the other (giving the so called 'difference in differences') provides an estimate of the improvement or decline in outcomes attributable to the DSCPs.

Further detail about the three strands of the quantitative analysis is provided below.

## Continuity of care from CARAT to CJIT

Data from DIMIS was used to measure continuity of care for clients transferring out of prison to the DIP. The analysis was based on Counselling, Assessment, Referral, Advice and Throughcare (CARAT)<sup>5</sup> referrals from the pilot prisons<sup>6</sup> (or in the case of the comparison areas, all prisons within the drug action team (DAT)) to the Criminal Justice Integrated Teams (CJITs) in the local area. The aim was to measure the percentage of successful referrals in each area over the period of interest<sup>7</sup>. A successful referral was defined as one with a corresponding CJIT pick up within six weeks of the prison leaving date.

The percentage of successful referrals in each of the six pilots and their corresponding comparison areas was then analysed using difference in differences to assess the impact of the pilot programme. Statistical modelling was also carried out to assess the statistical significance of the changes whilst controlling for client characteristics; whilst the comparison areas were carefully chosen to match the pilot areas, it was nevertheless prudent to control for client characteristics where possible.

## Continuity of care from CJIT to community

Quarterly DIP to NDTMS reports were used to measure continuity of care for clients referred by the DIP to community treatment. These data took the form of spreadsheets containing aggregated counts for each DAT and were available by quarter. Data were summed across the relevant DATs to obtain totals from which the percentages of clients triaged within six weeks of referral during each period were calculated.

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<sup>5</sup> CARAT is the key non-clinical gateway drug treatment service in prisons for prisoners aged over 18. It plays an integral part in the management of drug treatment in prison and in securing access to treatment on release in order to reduce harm caused by drugs.

<sup>6</sup> The term 'pilot prisons' refers to specific prisons that were working with pilot areas to affect system change.

<sup>7</sup> The analysis is based on referrals rather than clients; a client may have had more than one referral within the period.

The percentage of successful referrals (i.e. triaged within six weeks) in each of the six pilots and their corresponding comparison areas was then analysed using difference in differences to assess the impact of the pilot programme. Changes in the base number of clients referred were also analysed using the same approach. In both cases, as the data was only available at the aggregate level, it was not possible to control for client characteristics.

## Effective treatment and successful completions

Data from NDTMS was used to derive two separate outcomes, effective treatment and successful completions, each of which were based on a client's latest journey within the period.

For the purposes of the evaluation the standard NTA definitions of 'effective treatment' and 'successful completions' were used. Therefore, a client was considered in effective treatment if the journey exit reason indicated that treatment had been completed or their journey length (up to the end of period) was greater than or equal to 83 days. A client was deemed to have had a successful completion if their journey ended within the period of interest and the journey exit reason indicated that treatment had been completed successfully.

The percentages of clients in effective treatment and with successful completions were analysed using differences in differences to assess the likely impact of the pilot programme. Statistical modelling was also carried out to assess the statistical significance of the changes whilst controlling for client characteristics.

More detail on the outcome definitions and analysis techniques used is available in Appendix B.

### 1.3.3 Component 3: Economic evaluation

Making changes to local drug treatment systems requires resources. The scale required reflects the nature of the changes being made and the time in which change is to occur. The purpose of a cost-benefit analysis is to assess the benefits delivered relative to the resource costs of bringing them about. For the DSCPs this requires a comparison of the value of the additional benefits delivered by the pilots in relation to the costs over and above the normal costs of delivering drug treatment.

From earlier economic evaluations there is a clear consensus that reductions in offending are the greatest potential single source of benefit (Department for Education, 2010; Davies et al., 2009; Godfrey et al., 2004). A recent report refers to 90 percent of the £15.3 billion per annum social costs of problem drug use being attributable to offending (National Audit Office, 2010, p4). The average cost of drug-related offending per drug user per annum in the UK has been estimated at £50,600 (National Audit Office, 2010, figure 8). Given this estimate it is not surprising that the single most prominent source of potential savings from drug treatment should be crime reduction benefits. The Drug Treatment Outcomes Research Study (DTORS) (Davies et al., 2009) found that the annual cost of reported offences by a problematic drug user (PDU) (now more commonly referred to as an opiate / crack user (OCU)) undertaking treatment fell by £10,618. This provides an annualised value for the crime reduction benefit from recruiting an OCU onto a treatment programme, albeit one that is subject to substantial caveats.

The other principal source of treatment benefits is an improvement in health outcomes for OCUs and the corresponding reduction in the use of health and social care services. Health outcomes can be valued using the standard methods applied in health economics<sup>8</sup>. The finding from DTORS was that the annual cost of health and social care for an OCU fell from an average of £4,543 prior to treatment to £1,423 during the year following a treatment start.

The longer term impact of treatment on the savings from reduced offending and improved health depends on whether the client remains in recovery following completion of treatment. Where abstinence is maintained, prospects improve. By combining earlier findings from interview-based studies such as DTORS with large scale studies of treatment outcomes (based on NDTMS data: NTA, 2011) analysts are making progress on models to estimate the potential benefits from drug treatment.

## Cost-benefit framework

The standard approach to economic evaluation of public sector investment projects, as set out in the Treasury Green Book (2003), is followed here. It involves treating the DSCPs as an investment in improving the efficiency of drug treatment delivery. The investment makes a positive return if the resulting efficiency improvements convey benefits that, suitably discounted, exceed the programme's costs. Although this method is widely used there are some challenges in its application to drug treatment programmes (Bowles, 2011) and to the DSCPs in particular. These include:

- implementation issues that might delay the emergence of indications of improvement;
- that benefits may be slow to emerge because service user treatment journeys are typically long and so the 'pay back' period may be extensive; and
- that benefits are the result of once-for-all changes and come in the form of improved treatment outcomes that may extend long into the future and be difficult to predict.

These challenges are discussed in more detail in Appendix A2.

## Economic evaluation strategy

The DSCP programme comprises a series of distinct pilots that made a variety of changes to how drug treatment services are commissioned and managed. The 'bottom line' for judging the programme is its impact on key treatment outcomes such as the reduction of offending and the improvement of health. Lags in the system, ranging from delays in implementation to the fact that it will be several years before the longer term effects on client recovery can be seen, are such that it will be some time until the final outcomes emerge and can be assessed. However, there are various indicators that can be used to assess the impact of pilot activity on output and intermediate outcomes that are likely to give a good sense of longer term outcomes. The indicators are assigned to five groups, as outlined below.

### 1. Costs

Making significant changes to managerial and commissioning systems is costly. The economic analysis will explore how resources were used to implement system change over the two year pilot period and how much of an additional burden they represented. Spending under the principal heads is examined for each pilot.

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<sup>8</sup> For a thorough treatment of the economic evaluation of health outcomes and health programmes see Drummond et al. (2005).

## **2. Outputs and activity**

The impact of the programme on final outcomes such as offending and health is to a large degree mediated through the scale of the effects on the DAT's outputs and activity. Improvements in the targeting or tailoring of treatment programmes or in the degree of coordination between custody-based and community-based agencies will become manifest in indicators such as the number of successful programme completions and the number of number treatment journeys started. Various ratios are used to explore and capture these effects.

## **3. Managerial economies**

Partnership working is potentially very demanding of staff time in terms of the meetings in which information is exchanged and agency actions co-ordinated. Re-engineering systems can provide an opportunity for rationalisation which allows the same objectives to be accomplished but with fewer time inputs. The scope for managerial economies varied widely between pilots and their heterogeneous nature prevented a detailed comparison of the scope for managerial economies, but the potential savings are investigated.

## **4. Outcomes**

Measuring the impact of the DSCP entails finding a way of estimating what would have happened in pilot areas had DSCP not been implemented. For purposes of cost-benefit calculations the methodology chosen for impact measurement purposes has to be based on outcomes expressed in a format for which valuations are available. The difference in differences approach discussed in section 1.3.2 is used to make allowance for local variations in funding and delivery. The findings (expressed in terms of percentage points) provide a basis for estimating changes in the number of clients in effective treatment and in the number of successful treatment completions. The methodology for estimating benefits is outlined in more detail in Appendix C4.

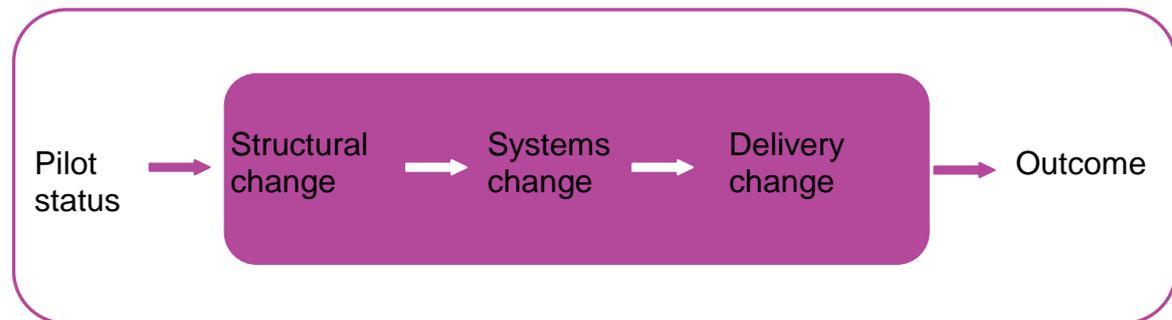
## **5. Cost-benefit analysis**

By combining the findings from DTORS (on the scale of harm before and after the start of treatment) and from the NTA (2011) study of treatment outcomes it is possible to make some provisional estimates of the returns to treatment. These estimates are then, in turn, used to explore the returns to the DSCP programme which set out to increase the effectiveness of the systems for commissioning and delivering treatment services. Appendix C5 sets out estimates of the harm levels, both short and longer term, associated with the various possible treatment pathways and Appendix C6 illustrates how these estimates are in turn used to estimate the present value of treatment.

## **1.4 DSCP theory of change**

The remit for the DSCPs was to test the potential to improve the way that drug treatment and related social provision was delivered by adopting more user-led, outcome-focused approaches at a regional and local level both in prison and the community. The pilot sites were given the opportunity to test and evaluate a variety of approaches throughout a two year pilot by using funding flexibilities and thinking innovatively about the commissioning, delivery and implementation of services within their region. A key element of the pilot was to get sites to work innovatively, and so the programme did not prescribe a detailed change pathway. However, an implied theory of change emerged through plans drawn up in pilot applications, the work they subsequently did with the central team to develop their plans, and discussions with the evaluation team to develop quantifiable outcomes. This emergent theory of change is represented in the diagram below.

Figure 1.1 DSCPs theory of change



As above, the DSCP theory of change involves three key stages. The first of these relates to changes at a structural level, including changes to the way drug treatment services are commissioned and the management of the system as a whole. The second stage is focused on system-level changes, which encompass changes to the organisation and delivery of services and how services work together along the recovery pathway. The final stage is related to changes at a delivery level, including improving access to a range of specialist and mainstream services and improving or adding services. In terms of service user outcomes, these changes are designed to result in a range of intermediate outcomes (engagement, retention, access to more appropriate and effective interventions) that lead to the ultimate outcomes the pilots and programme were aiming to achieve; recovery, re-integration and reductions in offending.

## 1.5 Report coverage

The rest of this report follows the structure indicated in the theory of change described above. **Chapter 2** focuses on the structural changes introduced by the pilot sites, while the next two chapters explore system changes, continuity of care (**Chapter 3**) and personalisation (**Chapter 4**). **Chapter 5** then describes the changes the DSCPs have made in the area of service delivery. **Chapter 6** explores pilot outcomes in relation to retention in treatment and successful completions and **Chapter 7** explores the economic costs and benefits. Finally, **Chapter 8** provides a summary of conclusions and reflects on the learning that can be drawn from the DSCPs.

Table 1.3 Summary of DSCP activity

Site	Freedoms and flexibilities <sup>9</sup>	Structural change	System change	Delivery change
Site 1	None	Structural change but not connected with pilot	Self Directed Support	Access to wider range of provision via SDS
Site 2	Pool/align CARAT/DIP budgets Relaxation of CARAT targets	Single CJS provider	Integrated criminal justice treatment system	Housing support ETE support
Site 3	None	Increased partnership working	Single Point of Assessment	Service user mentors Support for mutual aid ETE support Housing support ITEP roll out
Site 4	Pool/align CARAT/DIP budgets Relaxation of CARAT targets and audit Restrictions on Bail absorbed into probation court function	Consortium of providers	Continuity via "linking" roles Integrated criminal justice treatment system	Service user mentors in prison and community Recovery groups Family support ITEP roll out
Site 5	Pool DIP/DRR budgets	No structural change	Continuity via "linking" roles Embedded criminal justice treatment provision within community provision	Family therapy pilot ETE support
Site 6	Pool/align CARAT/DIP/police budgets Relaxation of CARAT targets and audit Relaxation of Arrest Referral targets	Consortium of providers	Continuity of case manager Integrated criminal justice treatment system	Service user mentors Housing support
Site 7	Relaxation of DIP reporting/monitoring	Consortium of providers	Independent case manager Self Directed Support (in year two of pilot)	Family group conferencing pilot Support for mutual aid ETE support ITEP roll out

<sup>9</sup> Freedoms and flexibilities are defined here as requests that required resolution at a national level. A number of freedoms and flexibilities requests were resolved at a local level and are not detailed here.

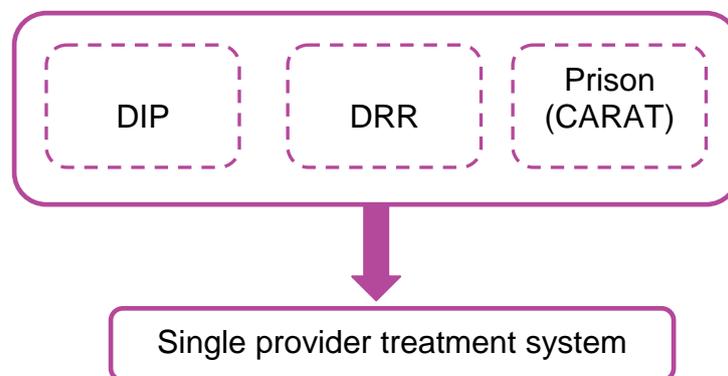
## 2 Structural Changes

Achieving substantive drug system change required sites to alter the structures of their treatment systems. This chapter explores how the DSCPs introduced structural changes to create more integrated systems. It first presents the ways in which treatment services developed single provider systems, before going on to discuss consortium approaches. The final section of the chapter explores how sites sought to address structural issues through increased partnership working.

### 2.1 Single provider treatment systems

A key innovation introduced by some of the DSCPs was to change the way services were commissioned so as to create a more integrated system. Whereas previous systems were perceived by staff and stakeholders to have resulted in fragmented treatment involving multiple contracts and providers, some of the pilot sites developed a single treatment provider spanning the criminal justice system (CJS). In site 2 a service was developed to include the DIP, the Drug Rehabilitation Requirement (DRR)<sup>10</sup>, and CARAT provision in custody. The clinical elements of drug treatment as provided through the Integrated Drug Treatment System (IDTS)<sup>11</sup> were not included within the single provider treatment system and continued to be delivered by the main prison healthcare provider.

Figure 2.1 Single CJS provider model



The main prison releasing offenders into site 5 was not geographically within the pilot area so only the DIP and DRR elements of the treatment system were integrated (not prison-based CARAT services). This site also moved to further integrate their community provision with their CJS provision - this is further explored in Chapter 3.

The aim of commissioning a single provider treatment system was to facilitate a single journey for the service user which would lead to greater continuity of care and therefore

<sup>10</sup> A Drug Rehabilitation Requirement (DRR) requires an offender to have treatment to reduce or eliminate dependency on, or likelihood to misuse, drugs.

<sup>11</sup> IDTS seeks to ensure that PDUs in prison have access to the same standard of treatment as those in the community. IDTS delivers clinical treatment such as substitute prescribing and psychosocial treatment such as group and one to one counselling in custody.

treatment effectiveness. A second aim of single provider services was to bring about cost efficiencies through creating economies of scale in the commissioning, contracting and governance arrangements of the service. Having a single provider also increased provider accountability for services. Rather than multiple providers being responsible and performance managed for individual elements of the service the single provider was instead responsible for the whole service.

### 2.1.1 Delivering a single provider treatment system

A number of factors impacted on sites' ability to deliver their single provider treatment systems: commissioning processes, relaxation of targets, workforce development, performance management and national CARAT procedures. This section explores each of these in turn.

#### Commissioning the service

In one site the local DAT commissioned a single service for DIP, DRR and CARAT services. This was facilitated through a request for the freedom to transfer the commissioning of CARAT services from the National Offender Management Service (NOMS) to the DAT. This was achieved through close collaboration with NOMS, which first required the design of a full service specification to ensure that appropriate quality standards would be maintained.

*“The primary fear that we would have, would be the disinvestment in the prison in favour of the community. So we were keen to reassure ourselves and colleagues that we wouldn't see our money disappear into something that we couldn't control.”*

*(Stakeholder, Site 2, Stage 2 interview)*

The process of releasing funding from NOMS to the DAT was complicated by the regional approach to the commissioning of CARAT services in the area. The funding for the local prison needed to be extricated from the regional CARAT contract, which was done through an existing break clause. The contract for the community elements of the treatment system was already coming to an end during the pilot, and in fact was extended for three months to accommodate the delays in releasing the CARAT contract resource.

A standard commissioning process was undertaken, with the tender being put out and bids invited. The commissioning board included key DSCP personnel alongside other organisations involved in the service (the local DAT, Primary Care Trust (PCT), police, probation and NOMS). The local prison was also involved. This was seen as important because the service would still be delivered within the establishment and affect the service users in the prison.

*“From the point of view of the commissioning process, the Head of Reducing Offending had a commissioning vote as well. And his view was very much focused on what was good for HMP [name of prison]. Whilst I, as well as that... was looking at the wider regional implication of it.”*

*(Stakeholder, Site 2, Stage 2 interview)*

As already mentioned, this site did not include the clinical elements of IDTS into their single provider service. To extricate the IDTS funding from the main healthcare budget within the prison was considered to be beyond the scope of the pilot. Instead, through the involvement of the PCT in commissioning the single provider treatment system, strong collaborative working between the single provider and the clinical elements of IDTS was established.

## Relaxation of targets

To facilitate engagement, it was essential that the prison operating in the single provider treatment pilot was not penalised through their key performance targets (KPTs) for their involvement in the pilot. To this end CARAT process targets were relaxed, in particular the number of comprehensive substance misuse assessments (CSMAs) which the provider was required to complete was reduced. The time requirement to start a CSMA for non-opiate / crack drug users was also relaxed from three to 15 days, while the target for OCU remained at three. These changes meant that the prison-based team were not “chasing” assessments in order to meet performance targets but could instead offer a more individualised service with greater opportunity to engage in meaningful interaction with service users.

## Workforce development

Upon successful award of the contract the CARAT staff within this site had their employment transferred to the new provider under standard transfer of undertaking protection of employment (TUPE)<sup>12</sup> regulations. Prior to receiving the DSCP contract the organisation commissioned to be the single provider only delivered DIP services in the area and was not involved in prison CARAT services. Therefore a considerable amount of familiarisation with prison delivery was required. In particular the provider was not aware of their responsibility for referrals into and post-programme reviews for the short duration programme (SDP)<sup>13</sup>. This led to them initially missing delivery targets and needing to allocate additional resources to this task.

The provider aimed to make the prison-based staff feel included in wider service delivery through the shadowing of roles and joint team meetings. However, due to additional responsibilities within the prison and staff shortages, shadowing of roles did not take place as envisaged. Staff reported that they did not feel part of the service as a whole, particularly existing prison staff that had not had their TUPE arrangements finalised. New staff joining the prison-based team undertook a community induction and consequently felt better integrated into the service.

## Performance management

The service was monitored by a single contract management board, as was normal practice in this area, and the prison continued to be involved in this process along with other stakeholders. However, the prison lead did not feel that performance management and monitoring was of the same standard as before due to case file reviews (to check the quality of service delivery) not being undertaken. At stage two of the research the prison lead was not able to take any delivery or performance issues directly to the provider, but instead referred to the DAT who took responsibility for this. This was challenging for the prison, as they thought they should be able to address performance issues directly.

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<sup>12</sup> TUPE regulations protect people when their employer changes, such as when a company is taken over or a public service is contracted out. TUPE regulations guarantee that an employee’s job transfers over to the new company, their employment terms and conditions transfer and that continuity of employment is maintained.

<sup>13</sup> SDP is a four week programme for prisoners with substance misuse issues which is based on cognitive behavioural therapy (CBT) and a harm minimisation approach for short term prisoners.

“Nobody said we can’t talk to them but it was almost as if to say... hold fire, it’s the commissioning partnership that should be talking to them about performance. But it’s quite difficult in terms of when you’re used to being hands on, managing, knowing exactly as well what’s going on to then... being more a bystander and overseeing that process.”

(Stakeholder, Site 2, Stage 2 interview)

Stage three of the evaluation found that this practice had changed as the pilot progressed and relationships between the provider, DAT and prison developed, in that the prison lead was able to go directly to the provider with any delivery issues. This had a positive impact, with the lead feeling more involved in service delivery within their prison.

Performance management also had an output and outcome focus. The DAT used local DIP dashboards<sup>14</sup> and NDTMS reports to track numbers in contact with the service in the community and custody each month, and also monitored outcomes through “*story boards*” compiled about custody and community service users.

“The DAT are really focused on it not being about just high numbers of people. They want us to be working with people to achieve outcomes and to show that what we’re doing is quality pieces of work with individuals and accessing people into treatment, which is really helpful.”

(Delivery staff, Site 2, Stage 3 interview)

In site 5 a criminal justice board was set up to oversee DIP and DRR provision. While the two services had previously been contracted to the same provider they had been treated separately from a performance management perspective. Having the two elements managed under the same board improved monitoring of DIP and DRR, and also assisted in creating a seamless transition for service users as any barriers to continuity of care could be addressed by the provider. Continuity of care is discussed further in Chapter 3. By the end of the pilot the criminal justice board had been incorporated into the local contract management and delivery meetings in the area.

## National CARAT procedures

Within the pilot area including a prison in their single provider treatment system there was concern that national CARAT procedures and prison KPTs could stifle innovation in the delivery of the prison element of the service. Although changes could be made to CARAT procedures and operating processes within the prison, it was felt that there were limitations to this as the service still needed to conform to national procedures to facilitate prisoner transfers.

“The key concern was that... there is a national specification for how the CARAT service will engage with an offender. The concern was that what was going to be delivered at [name of prison] was going to be outside that... So the ones [prisoners] who were moving on they had to have a service that was compatible with the national service that they would then engage in wherever else they went to.”

(Stakeholder, Site 2, Stage 2 interview)

As the pilot developed the provider was able to make more changes to delivery within the prison while also meeting national requirements. For example, within the prison an IDTS drop-in clinic was set up so that prisoners in receipt of IDTS had greater access to CARAT support at times of need. In addition, changes made to performance monitoring by the DAT (discussed above), were seen to result in the CARAT service being run less

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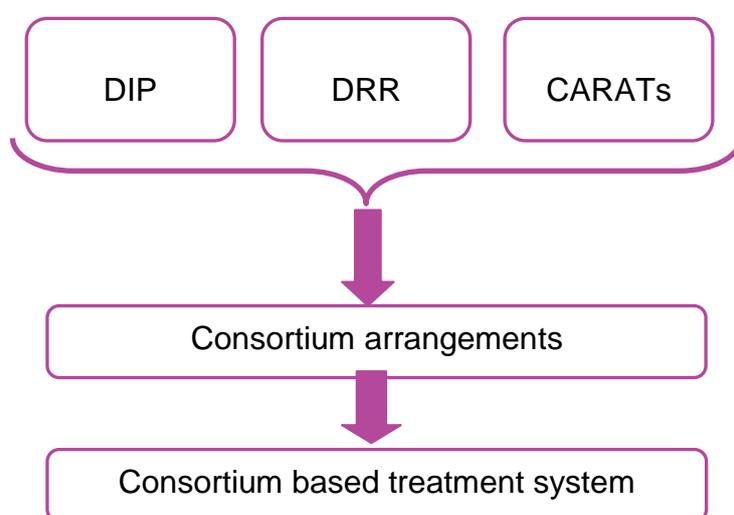
<sup>14</sup> The DIP dashboard is used to manage DIP processes. It contains data on four performance indicators; the percentages of positive and negative tests, and the percentages taken onto case load and commencing treatment.

prescriptively, with a greater focus on outcomes over process. These changes were facilitated by an increase in staff capacity resulting from the reduction in delivery targets as detailed above

## 2.2 Consortium based treatment systems

A second approach to restructuring treatment systems was through the establishment of a consortium based system where a number of separate providers delivered services as a consortium. Two sites focussed on delivering an integrated CJS, including the community DIP and prison CARAT services (see figure below), while another targeted their consortium arrangements on community provision in their area.

Figure 2.2 Consortium based CJS model



Consortium based approaches were undertaken to ensure greater collaboration between partners and therefore increased continuity of care. As with the single provider treatment systems, sites implementing consortium approaches also aimed to reduce the costs associated with commissioning, contracting, and governance arrangements.

In two areas, a consortium based treatment system had been implemented as an interim measure prior to commissioning a single provider service at the end of the pilot - standard commissioning cycles were out of sync with the pilot period and so undertaking a full commissioning process within the limited pilot timetable was unfeasible. Another site took an alternative approach and saw the establishment of a consortium approach as the preferred way to maintain the diverse range of services available in the area while maximising partnership working.

*“It’s around the service user having choice, it’s about keeping diversity. We’ve got a very diverse population... We have less people accessing drug treatment where there isn’t a local provider, so we don’t want to reduce that anymore, and potentially have people drop out of drug treatment and then go on to continue to commit crime or even die because they’re overdosing.”*

*(Stakeholder, Site 7, Stage 2 interview)*

Despite this, the merits of commissioning fewer providers in the future were acknowledged by one stakeholder who felt that this would streamline future provision and reduce treatment system costs.

## 2.2.1 Delivering a consortium treatment system

There were two approaches to the development of consortium arrangements within the three pilot sites. The first involved setting up **working agreements** between the various providers. These were set up to ensure that all providers were working to a common set of objectives, with a commitment to hold each other to account if partners were not performing.

“[We are] agreeing to be part of this system which says that you will challenge each other; you will look at each others performance; you will be the drivers of change; you will be looking at how we’re performing against the national indicators and you may change sort of accordingly on the back of that.”

(Stakeholder, Site 7, Stage 2 interview)

Delays to the set up of agreements occurred because of the need for local authority sign off. This was to ensure that the service requirements set by each of the individual funders would still be met through the provider consortium.

The other approach to developing consortium arrangements involved appointing a **lead provider** to take responsibility for the consortium as a whole. This involved the lead provider taking responsibility for the development of the service and reporting to the DAT on performance, while a service management provider was responsible for the day to day running of the service and managing delivery staff. Both providers were identified by the consortium, demonstrating that these organisations were respected amongst their peers.

A number of factors impacted on sites’ ability to deliver consortium arrangements. These were: contracting freedoms and flexibilities; clearly defined roles and responsibilities; partner engagement; changes to targets; governance arrangements; and performance monitoring, and are discussed in turn below. Distinctions will be made between the sites that established working agreements and that which appointed a lead provider.

### Contracting freedoms and flexibilities

Changes to the management of contracts had been made in one of the sites that set up a consortium based treatment system, where the CARAT contract was transferred from the prison and held by the PCT (DAT) for the duration of the pilot (technically known as being ‘novated’). This was done to facilitate a continuous case management system whereby all case management staff rotated in and out of the prison rather than being solely community or prison-based (further explored in Chapter 3). Staff terms and conditions across the two main provider organisations were aligned in terms of working hours and salaries. This was facilitated through the contract transfer, which changed from stipulating the number of staff in post to a block activity contract<sup>15</sup>. Additional money, which was available through staff vacancies, was used to increase CARAT staff salaries to match those of the community-based teams. The novation of the CARAT contract to the DAT gave the DAT formal monitoring responsibilities for the prison element of the service.

Another site took a sub-regional approach to their consortium arrangement, developing the service across three local authorities to create a more coherent and continuous treatment system. The time and effort it took this site to set up their partnership agreement and combine funding across three local authorities highlights the complexities involved in seeking to integrate commissioning at a sub-regional level.

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<sup>15</sup> A block activity contract is where a provider is contracted to deliver a service regardless of the number of staff employed and service users in receipt of the service.

## Clearly defined roles and responsibilities

Clarity around roles and responsibilities and clear accountability mechanisms are often cited as factors underpinning strong partnership working (Berry et al., 2011). In the DSCPs, working agreements established a legal basis for service delivery and gave the local DAT more authority in challenging the performance of providers within the system where necessary and to encourage collaborative working.

“It’s [the working agreement] ensuring that they are all working together rather than just... this is the wish of the Safer Communities Partnership, this is about how you’re going to work in some form of a semi-legal context of a contract... ensuring that they work right across the whole treatment system not just for their own organisation.”

(Stakeholder, Site 7, Stage 2 interview)

In contrast, where a lead provider consortium was set up, stakeholders felt that the informal nature of the arrangements meant that the lead provider had insufficient authority to challenge delivery of providers if need be. It was felt that the lead provider would have been able to take more formal responsibility for the service if they were contracted as a lead provider and the second provider was sub-contracted to them.

## Partner engagement

A key facilitator to sites being able to set up consortium treatment systems was the engagement of local providers and their desire to be involved in pilot activity. This was especially important where there was no contractual commitment to do so.

As discussed, prisons were central to sites being able to operate single provider systems, and this was equally important for consortium approaches - two sites had opted for a consortium approach in order to increase continuity of care between prison and community treatment. Site 4 had set up a contract between their local prison and the DAT which specified that the DAT would commission a service which met the needs of the prison. This contract also included a break clause whereby the contract could be terminated if the service was not meeting the prison’s needs.

“We’ve entered into a proper contract... via our procurement branch [so] we will actually contract with [name of local authority] to deliver the service on our behalf. So there is a little bit of reassurance built into the fact that we have a proper contract so we will give them the money, if we’re not happy there will be a break clause and we’ll say actually this isn’t working, we want to withdraw our funds.”

(Stakeholder, Site 4, Stage 2 interview)

The engagement of local PCTs was also crucial when delivering consortium based treatment systems within prison settings. Where the clinical elements of IDTS were not integrated into the consortium arrangements increased partnership working between PCTs and DATs was essential. While in one site the PCT were involved in the pilot and sat on strategic boards, the PCT in another was not so receptive to joining the consortium or pooling the IDTS clinical funding.

“For me, it’s one of the biggest failings of the pilot... that we didn’t pool it all, because... the clinical parts of IDTS are still outside our governance, and even though we’ve asked the PCT to sit on the Sub-regional Commissioning Board, the Criminal Justice say that they won’t; they have their own structures.”

(Stakeholder, Site 4, Stage 3 interview)

While the PCT encouraged more joint working between the consortium providers and the clinical provider, staff felt that support from the clinical provider could not be guaranteed as it had not been formalised and they were still subject to their own delivery targets.

## Changes to targets

Changes to targets had also been granted as part of the freedoms and flexibilities in two of the consortium pilot areas. These were predominantly around the relaxation of CARAT targets in prison which were included in the prison's KPTs. Specific changes included extending the timeframe for the start of the CSMA and allowing the use of existing community assessments rather than requiring a new CSMA be completed for each referral. The move away from completing the CSMA and process delivery targets marked a considerable change for prison staff and they required training and support in case management and motivational interviewing as the services moved away from the more traditional assessments they were familiar with.

## Governance arrangements

Management and governance are critical when delivering a new service through consortium arrangements; they ensure that partnership agreements are adhered to but also that delivery and innovation are driven forward. To this end governance and contract management meetings were set up and brought about improved working relationships between providers and commissioners.

Effective governance is clearly crucial at the beginning of a pilot but also needs to continue throughout in order to drive forward pilot aims and objectives. In one site the governance structures were disbanded and subsumed into the management groups established to deliver Integrated Offender Management (IOM)<sup>16</sup> before the end of the pilot. While this was done to reduce burden on strategic staff who would have been involved in both groups, key stakeholders and delivery staff felt that the pilot lacked motivation and direction for the final six months of the pilot and so would have preferred the specific DSCP governance structures to continue.

*“The steering group allowed a specific focus on the SCP and its development at fairly senior level for a period of time. And I think when that was disbanded that was a bit of a loss really. SCP didn't really get that significant buy-in from some of our senior partners after that period.”*

*(Stakeholder, Site 6, Stage 3 interview)*

## Performance monitoring

As with the introduction of a single service provider there were also changes to the performance management processes undertaken in the consortium based sites, with the 'system' itself managed rather than the individual elements. Three features were identified as leading to successful performance management within consortium based treatment systems: clear and transparent communication; information sharing; and clear reporting processes.

Clear and transparent communication between providers is critical to effective performance monitoring. Regular partnership meetings facilitated communication between providers.

*“All of the services we all get together bi-monthly and talk about... what progress we're all making, so obviously we always talk about system change and keep people up to date on what's happened so far, so the communication it's there between us all.”*

*(Delivery staff, Site 4, Stage 2 interview)*

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<sup>16</sup> IOM is an overarching framework that allows local and partner agencies to come together to ensure that the offenders, whose crimes cause most damage and harm locally, are managed in a coordinated way.

Meetings also facilitated information sharing; an important mechanism for effective partnership working more generally (Phillips et al., 2002) and which had a central role in performance management within DSC consortium approaches. Barriers to information sharing included consortium providers not wanting to expose their own weaknesses or business confidential information. Where partnership agreements were in place, the DAT used the terms of these agreements to encourage openness between providers. Without such agreements the DAT lacked sufficient authority to bring about improved communication and information sharing.

When operating a consortium approach to the delivery of a treatment system it is also important that clear performance reporting processes are established with set targets to be met. In one site, where the DAT had not established a performance framework for the pilot the lead provider developed one. However, it was felt by some stakeholders to neglect the national measures used by the NTA and in fact masked inadequacies and poor performance in the system.

Clear performance management structures are also important when monitoring prison-based delivery. Concerns were raised about the DAT performance monitoring within one of the sites. It was felt that insufficient monitoring had resulted in deterioration in service quality; prisoners were not being seen within a set period of time after entering the prison and not engaging with CARAT provision. Closer monitoring could have revealed any issues arising with the perception that they could have then been addressed sooner.

*“Once we realised that the reporting was not right we looked at that more closely and problems did emerge. And they were confirmed by the prison who said that they were struggling with certain elements. We worked in some detail with the prison actually in terms of commissioners going through the detail with them and what we could do to try and improve it.”*

*(Stakeholder, Site 6, Stage 3 interview)*

While reports form a central part of performance monitoring it was also important that DAT commissioners were kept abreast of day to day delivery. Site visits were sometimes used to review performance, with feedback fed into service delivery plans. Where no site visits or consultation with staff occurred it was difficult for managers to report on service performance.

## 2.3 Partnership approaches

A third approach to changing treatment provision at a structural level was the development of partnerships between providers. These partnerships were not formed through consortium agreements or service re-commissioning but instead through increased co-operation and joint working. The need for increased partnership working was measured in one pilot by using the Organisational Readiness to Change (ORC) tool, which assessed how ready staff and organisations were for changes to their working practices. The Client Evaluation of Self and Treatment (CEST) tool was also used with service users to identify where improvements could be made within the treatment system.

### 2.3.1 Delivering partnership approaches

The following features were felt to impact on the creation and delivery of partnership approaches.

## Staff training and development

One pilot area undertook a programme of joint staff training and development to address issues raised in the ORC and CEST assessments. Features included joint inductions for all staff working in the area regardless of the provider they were employed by and role shadowing, alongside a wider training programme. It was thought that this had led to improved understanding among delivery staff of external colleagues' roles and how their services complemented each other.

## Regular meetings and communication

Regular meetings between managers where any issues within the treatment system could be addressed were felt to facilitate information sharing and ensure that providers did not feel that they were competing for service users. Communication was further facilitated in one site by clear guidance from the DAT in terms of expectations of the pilot. Providers reported that their relationship with the DAT commissioners had changed as a result of their involvement in the pilot and the improved communication. The DAT were now viewed as a partner involved in the delivery of the service who could be approached for support if challenges were faced.

*“Once you start looking at the DAT as a system that’s there to help and support you and not something that can take away a commission - that historically has been a fear.”*

*(Delivery staff, Site 3, Stage 3 focus group)*

While partnership working had improved across this site, no formal agreements were in place to support it, with the approach relying on individuals maintaining these positive relationships. As such, there were potential challenges around the sustainability of this approach in the long-term.

Regular performance management meetings also took place between the providers and the DAT in this area. While delivery staff felt that there were a lot of targets associated with delivery, these were not necessarily viewed negatively as they demonstrated the nature and extent of progress and results could be used to drive performance forward. The providers were also able to view each other's performance data in the spirit of collaboration which facilitated joint problem solving.

*“All the providers when you speak to them have noted, particularly the ones who have worked in other areas, that this is a really different way of working in [Pilot site]. It’s much more partnership focused, it’s much less competitive between providers and there is really that kind of joint work that you don’t necessarily get in other areas.”*

*(Stakeholder, Site 3, Stage 3 interview)*

## Working groups

An alternative approach to partnership working adopted in another pilot area focused specifically on building relationships with mainstream service providers with the aim of raising awareness of the needs of drug treatment service users, and encouraging mainstream providers to take responsibility for meeting these needs within mainstream settings. This approach was fostered through the creation of a number of working groups, focusing on key areas of provision, and drawing on a range of statutory and non-statutory partner agencies to take the agenda forward. Central to this approach was the concept of working in partnership to use existing resources in innovative ways.

*“It is a bit about changing the mindset rather than having additional resources... I think it’s been a useful thing... It was part of a culture of trying to develop partnerships and take a broader view about things.”*

One example of this form of partnership working involved the formulation of a Children and Families working group with the aim of looking at how mainstream services in this area could better meet the needs of drug treatment service users. Outcomes from this group included the piloting of family group conferencing within a prison setting. The role of the pilot implementation board in supporting the development of these working groups, alongside the support of senior stakeholders, were identified as key facilitators to the success of partnership arrangements of this kind. In addition, stakeholders involved in this form of inter-agency working stressed the importance of having clear aims and objectives to support partner agencies to take the agenda forward. These arrangements were felt to have value because of their potential to enable agencies to share resources and reduce duplication. However, there was concern that informal partnerships were vulnerable to retrenchment during times of economic austerity and that the introduction of the Drug and Alcohol Recovery Payment by Results (PbR) pilots<sup>17</sup> could mitigate against effective partnership working as providers would be in competition for achieving outcomes.

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<sup>17</sup> The Drugs Recovery PbR pilots will aim to provide a transparent funding system for drug recovery services based on the achievement of high level and interim outcomes.

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## 3 System Changes: Continuity of care

Continuity of care within drug treatment, particularly within the criminal justice system, presents a number of challenges to commissioners and service providers (NTA, 2009a). Guidance developed in 2009 as part of IDTS acknowledged the large number of different agencies and staff involved in an individual service user's journey and described the potential for confusion and inconsistency (NTA, 2009b). The potential for service users to experience disjointed treatment, duplication of assessments, and a 'stop start' treatment journey that reduces successful treatment outcomes is a key concern for both policy makers and practitioners (Patel, 2010).

Reflecting these concerns, tackling continuity of care within the treatment system was a priority for a number of pilot areas, particularly in relation to improving continuity between prison and community-based services. Pilots highlighted the complexity of existing treatment systems with a range of agencies working across multiple settings, often commissioned and funded separately with diverse performance monitoring arrangements, case management systems, assessment and referral paperwork and target populations. A range of approaches were adopted to address treatment continuity in this context and the strengths, weaknesses and impacts of these approaches are the focus of this chapter.

### 3.1 Aims

Pilot sites focusing their activity on continuity of care did so with the belief that improving continuity of treatment would enhance service user engagement, avoid disrupted and disjointed treatment experiences, and ultimately improve service user outcomes. It was also hoped that improving continuity within the criminal justice treatment system would reduce drug-related reoffending. In tackling continuity of care, pilots explored three distinct approaches, which were:

#### 1. Ensuring continuity within integrated criminal justice drug treatment systems

Integrated community CJS and prison drug treatment teams, working as a single entity with an overarching governance structure, integrated performance management and operating as an integrated team, designed to promote seamless continuity of care.

#### 2. An independent case manager

Continuity of case management across the criminal justice treatment pathway and different providers, supporting the service user and acting as an independent broker of services, promoting a seamless treatment experience.

#### 3. Embedded CJS teams

Continuity of care fostered by embedding DIP outreach teams within community drug treatment to facilitate transitions from criminal justice pathways into the community.

To supplement these distinct models, a fourth approach was included in some pilot areas, in addition to one of the other approaches described above:

#### 4. Continuity via linking roles

Continuity of care facilitated by through the gate support, focusing on key transition points within the CJS treatment system.

The rationale for adopting each approach, how they were implemented and the strengths and weaknesses of each are discussed below.

## 3.2 Continuity within integrated criminal justice treatment systems

As discussed in Chapter 2, creating integrated criminal justice treatment systems was one way in which pilots sought to tackle continuity of care. However, structural change on its own was not enough to ensure this. The DSCPs who had developed integrated systems also introduced a number of changes at a treatment system-level to facilitate continuity along the treatment pathway. These changes were case management; performance management; assessment, referral and care planning paperwork; and communication, and are discussed in turn below.

### 3.2.1 Case management

Two approaches to case management were adopted by sites piloting integrated CJS treatment systems – continuity of case manager and non-continuous case manager. The strengths and weaknesses of these approaches are explored here.

#### Continuity of case manager

In this model, a core element of the integrated system was the introduction of a case manager that worked across all criminal justice settings. To promote continuity and consistency the case manager worked with the service user from arrest, through court, into prison and on their return to the community. Fundamental to this approach was the theory that consistency in case management fostered a therapeutic relationship between the service user and their case manager, and that trust and rapport were key to a successful treatment journey<sup>18</sup>. It was also hoped that this continuity would improve retention in treatment by improving the flow of information through the system, reducing duplication of assessments and creating a more seamless treatment experience.

The introduction of the continuous case manager model across the CJS was a significant change to existing structures. Arrest referral workers, community DIP team workers and prison CARAT workers were combined into a single enhanced case management team operating across all settings, taking on the role of enhanced case managers and following their service users throughout their treatment journey. The creation of an integrated treatment system with aligned funding greatly facilitated this model of case management, enabling staff to be managed as a single team irrespective of which part of the treatment system they had previously been funded and employed by. However, this approach made for implementation and delivery challenges, discussed below.

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<sup>18</sup> This is also the premise of the National Offender Management Model (Turley et al., 2011; NOMS, 2005).

## Implementation challenges

Implementation challenges are conceptualised here as those that arose during implementation that with time could feasibly be addressed and overcome. They comprised training and skills; pay and conditions; and security considerations.

### *Training and skills*

The enhanced case manager role required staff trained to work in specific settings to adapt to unfamiliar environments, and utilise different skill sets and ways of working. Adapting to the secure environment of prison, and grappling with the different paperwork, protocols and targets of different settings were amongst the issues raised by staff as particularly challenging.

**Respondent 1:** “[We have] three different processes and three different working environments, you’re either in a police station, a prison or in [the community office]... It was really difficult, coming from the community to working in the prison... all the rules that were imposed on us.”

**Respondent 2:** “I think it was very difficult, I mean for the guys who’d never worked in a prison before they were just thrown in the deep end... It’s a different job altogether. »

(Delivery staff, Site 6, Stage 2 focus group)

The challenge of ensuring staff were adequately equipped and trained to fulfil their new role was exacerbated by the limited time frame for implementation during the two year pilot period, and staff retention and service quality were felt to suffer as a result.

### *Pay and conditions*

Differences in pay and conditions between staff previously employed as CARAT, DIP and arrest referral workers had to be reconciled to facilitate the enhanced case manager role. This was found to be complex, time consuming and difficult to achieve during the life of the pilot.

### *Security clearance*

The enhanced case manager approach presented logistical challenges in terms of ensuring all staff had the appropriate security clearances for working in prison and police settings. Resolving these issues caused significant delays, and managers reported waits of up to six months to gain security clearance. Inevitably these difficulties led to staff shortages, placing additional strain on the service.

## Delivery challenges

Delivery challenges are conceptualised here as issues that, unlike implementation challenges, were less easily addressed with the passage of time. These took the form of logistical challenges and issues relating to the composition of the prison population.

### *Logistics*

A key premise of the enhanced case manager approach was that the role would enable staff to follow service users from the community, into custody and out again to ensure continuity of care. To achieve this, a high degree of flexibility was needed within the system to enable case managers to move between settings and respond to service users’ needs. However, to ensure all settings were adequately staffed, enhanced case managers worked on a rota basis which limited their ability to work flexibly to meet the needs of individual service users. Case managers could not always attend appointments with service users, meet them on release from custody or support them in court because they had to be in a particular setting.

“Sometimes you get clients and they... really want to meet with you or you would like to go with them for some appointments but you can't because you need to be in prison, you need to be somewhere else.”

(Delivery staff, Site 6, Stage 2 focus group)

These challenges were reflected in the account of one service user who spoke positively about seeing the same case manager in prison and on release, but was frustrated at the limited flexibility his case manager had.

“I'll ask [my continuous case manager]... to meet me somewhere else and... he says 'Oh, I can't see you Monday. Prison Tuesday, work Wednesday, I can't do that Thursday. Forget this week; next week, can't do Tuesday, can't do Wednesday... I tell you what, I'll ring you next week on Friday and make sure you're alright', and that's how it is... He's [in] the prison and everywhere... it's not practical.”

(Service user, Site 6, Stage 3 interview)

### *Prison population*

The enhanced case manager approach tackled continuity of care by ensuring that prisoners released from the pilot prison (who were released into the local area) retained the same case manager. Staff and stakeholders reflected that there were limitations to this approach because only a minority of prisoners were released into the local area. In recognition of this, protocols were put in place to improve out of area referrals and these improvements were seen as a positive element of pilot activity. However, at stage three of the research, it was felt that the issue of limited prisoner releases into the local area jeopardised the success of the approach, as only a minority were eligible for the continuous case manager service. The rotation of staff in and out of the prison to deliver the enhanced case management approach placed strain on meeting need within the prison by reducing the number of staff available at any one time. Consequently the service struggled and the prison developed a back log of cases. By stage three, the pilot had sought to address this issue by increasing the number of staff based solely within the prison.

### **Post-pilot plans**

The enhanced case manager role trialled during the pilot was not rolled out post-pilot. Instead the intention was to re-introduce a full time prison-based team, distinct from a community-based team, who would continue to provide an enhanced case management service for prisoners resident in the pilot area by increased levels of prison in-reach. The decision not to continue with the approach trialled reflects the logistical challenges of delivering an effective service of this kind. While staff reflected positively on the increased communication and learning that stemmed from working across the different settings, the model was not felt to be viable in the long-term.

### **Non-continuous case managers**

In contrast to the continuous case management approach, two of the pilot areas opted for an integrated CJS treatment system, but retained staff specialisms. In these sites, staff employed as prison CARAT workers retained their roles, and staff employed as community CJS workers largely kept theirs, although in some cases they were expanded to incorporate additional elements. The rationale for choosing to retain staff specialisms was that rotating staff in and out of prison was felt to add an additional level of uncertainty to the structure for both staff and service users. Instead, the hope was that a less formal process of work shadowing would give staff the opportunity to experience different roles across the treatment system and enhance understanding and communication. Regular integrated team meetings and training sessions were also prioritised as a way of ensuring all members of staff were aware of other roles within the team. Within these pilot areas, less focus was placed on continuity facilitated by a case manager, with greater emphasis on continuity of processes including seamless

integration of information systems, assessment and referral paperwork and performance monitoring. The facilitators and challenges to achieving integration of these functions will be discussed in more detail later in this section.

### **Implementation challenges**

#### *Secondments and shadowing*

To promote continuity of care, improve communication and facilitate shared understanding, sites operating non-continuous case management sought to implement work shadowing and secondments. Where this was implemented successfully it was positively received.

“We’ve just seconded... two of the treatment workers from [community-based CJS team] into the [prison-based] team... They’ve come in with fresh eyes, positivity... [and] knowledge about how it works in the [community team] and obviously they’re also learning about how it works for us and they’ve still got those links with the team outside to be able to pass that information on.”

(Stakeholder, Site 4, Stage 3 interview)

However, staff shortages in one pilot area made it difficult to implement such opportunities and staff felt this had impacted negatively on their understanding of each others’ roles and perception of themselves as an integrated team.

### **Post-pilot plans**

In contrast to the site piloting the continuous case manager approach, both sites piloting integrated CJS treatment systems that retained staff specialisms planned to keep the model post-pilot. Positive impacts of the model reported by staff included improved communication between different elements of the treatment system, increased in-reach visits from community-based staff to prepare prisoners for release and a shared sense of accountability across all elements of the system to ensure continuity of care throughout the treatment journey.

## **3.2.2 Performance management**

Performance management structures that supported an integrated treatment system and promoted continuity of care were viewed as an important facilitator to effective treatment. Structures and systems put in place by pilots to achieve this included creation of whole system performance management frameworks and reconfigured performance management measures and targets.

### **Whole system performance management frameworks**

In creating integrated treatment systems, pilot sites were presented with the opportunity to create performance management frameworks that supported and facilitated this whole system approach. For example, in one pilot area, previous performance management structures that focused on treatment within individual settings were replaced by a single whole system performance management framework encouraging a more joined up approach with greater emphasis placed on transition points and how service users moved through the system. In sites that had adopted a consortium based approach to integrating services (discussed in Chapter 2), these overarching performance management structures were considered crucial to ensuring partners worked to one set of common aims and objectives, and shared responsibility for service delivery.

By stage three of the evaluation, staff and stakeholders had identified a number of facilitators that were felt to support such developments. These included early consideration of performance monitoring in pilot design and dedicating resource to improving data quality and data sharing by, for example, employing a data analyst.

Consultation with staff across the treatment system to identify the key performance indicators was also viewed as essential, as was strong engagement and direction from commissioners. Where these foundations were not in place, staff reported difficulties in maintaining effective performance monitoring structures which in turn undermined the effectiveness of pilot activity.

In developing integrated treatment systems, particular consideration needs to be given to ensuring that all partners have clear channels through which they can raise performance issues in a timely way. This was of particular concern to stakeholders who had previously been responsible for monitoring performance of services, but who had devolved this responsibility to the wider local partnership as part of measures to tackle continuity and coherence within the system.

## Performance measures and targets

A key issue for pilot sites introducing an integrated service was how to create an environment in which new ways of working could be explored without key elements of provision being penalised for not adhering to targets under the old system. For example, CARAT targets for completion of Drug Intervention Records (DIRs) were thought to be too process-focused and time consuming, inhibiting effective engagement with the overall pilot aims and objectives. These issues were particularly pertinent for pilots that were seeking to develop consistent assessment, referral and performance management paperwork across the treatment system, where targets tied to pre-pilot paperwork had the potential to jeopardise successful implementation.

Across all three pilot areas adopting an integrated system, some form of relaxation of DIR targets was granted under freedom and flexibility requests. An important element of this freedom was exemption from CARAT audit (which judged performance on process-related targets that pilots were seeking to move away from). Without this, opportunities to explore new ways of achieving continuity of care would have been undermined. While the ability to request and access freedoms and flexibilities of this kind was viewed very positively by stakeholders and providers, a number of challenges remained. In particular, despite being granted exemption from some targets, sites still felt there was progress to be made in terms of streamlining processes across the system and achieving coherence in relation to targets and performance management reporting mechanisms. Running a pilot within a wider system that continued to operate within existing performance management models also caused difficulties. Examples of the issues this raised included queries in relation to what implications changing practices at a local level would have when service users were transferred to prisons outside the pilot area. Whether receiving establishments would accept non-standard paperwork, and what implications this might have for their own working practices, continuity of care and audits were issues that areas tackled.

From April 2011 new government guidance replaced DIR completion in prison settings with a minimum dataset for performance monitoring purposes, designed to streamline reporting and reduce burden (Home Office, 2011). These changes mirror the freedom and flexibility requests that were piloted locally in some DSCPs regarding DIR completion, at a national level. While it is beyond the scope of this evaluation to explore the impact of this wider change, it is reasonable to anticipate that it will go some way to alleviating the challenges pilots faced in operating within a wider system with an incompatible performance management model.

### 3.2.3 Assessment, referral and care planning paperwork

Linked to streamlining processes in relation to targets and performance management, sites developing integrated systems were faced with a substantial challenge in rationalising paperwork across the system. Ensuring consistency of assessment, referral and care planning documentation was thought to be a key way in which pilot areas could improve continuity of care and improve treatment experiences for service users while simultaneously reducing bureaucracy and duplication.

“I think the biggest problem has been that I have had to start again and again... I mean I went in to jail and I had four months in there where I got settled down... and I was seeing the CARATs workers there... I was out for six months, squatting and living in different places with different people and it was like starting all over again... Then I go back to jail and again it's a new start. So it's kind of very up and down... there was no one person who I saw the whole way through... I've had to go over the same things... If they had my initial statements and everything then they could've maybe seen my progression and then sort of worked on that basis rather than again started from scratch.”

(Service user, Site 2, Stage 2 interview)

Work to achieve this was ongoing in all pilot areas. In one site for example, where previously a community treatment worker preparing for the release of a prisoner would have completed a full assessment, staff were now using the CARAT CSMA and updating this with various mapping methods (discussed further in Chapter 5). The advantage of this was that service users were not required to go through an unnecessary assessment and staff had more time to focus on the service user and their treatment needs. While some progress had been made, repetition of paperwork and duplication across the system continued to be a challenge to successful implementation of an integrated system, as the example above indicates. A barrier to streamlining these processes included adherence by some commissioners to targets and performance monitoring protocols that required staff to continue utilising multiple sets of paperwork across different settings. Reasons for this may be related to the lack of integrated IT systems which meant there was a need to record activity across a number of incompatible systems (see section 3.2.4 below), and therefore to collect this data in varying formats. These issues were perhaps most visible in the pilot area that had adopted a continuous case manager approach where case managers reported completing multiple sets of paperwork as their service users moved through the treatment system.

**Respondent 1:** “Even within the team because we all fill out paperwork in the police stations... you have to fill out another set of paperwork in the prison and it's all the same thing.”

**Respondent 2:** “There's a lot of irrelevant paperwork... If you're picking up at the station and it's now end to end... now you refer them to yourself, they go to the prison, you then refer them to yourself from the prison, they come out of prison and you refer them back to yourself. »

(Delivery staff, Site 6, Stage 2 focus group)

That further progress needed to be made in streamlining paperwork and reducing duplication was widely acknowledged. Staff and stakeholders identified it as a key area where improvements could bring huge benefits for service users and staff. By the end of the pilot period changes were being made at a national level to the prison-based CSMA's, with the intention of creating a more focused streamlined assessment process. This development, coupled with the minimum dataset for prison monitoring discussed above, may help to alleviate some of these concerns post-pilot.

### 3.2.4 Communication

Timely and accurate transfer of information and effective communication are factors widely acknowledged to support successful partnership working (Berry et al., 2011; Patel, 2010) and were viewed by pilot areas as vital to successful continuity of care. Pilots adopted a number of methods to address this issue.

#### Integrated IT systems

A primary barrier to successful communication across the treatment system was thought to be the lack of integrated IT systems. The criminal justice treatment system relies heavily on paper-based assessments and referral paperwork but in a system with multiple settings including police stations, courts, community providers and prisons, this was widely felt to be unfit for purpose. Two approaches were adopted to tackle this.

##### **Web-based whole system case management system**

One pilot area intended to address this issue by introducing a web-based case management system accessible to all staff throughout the treatment system, in order to reduce duplication of paperwork and create a timely flow of information. Stage three of the research found that at the end of the two year pilot period the system was operational in criminal justice community settings but had not yet been implemented in the prison, although this was thought to be imminent. The delays in implementation resulted from security concerns, IT infrastructure issues, and the need to ensure the system was fit for purpose and would meet the case management and reporting requirements of all elements of the integrated CJS treatment system. The delays frustrated pilot delivery staff, who continued to rely on phone and paper-based communication.

##### **Prison read-only access to community-based case management systems**

An alternative to the approach described above was the implementation of read-only access to community-based management systems within the prison setting. The limitation of this approach was that information flow would be in only one direction, however, it had the advantage of being relatively straightforward to achieve within the time constraints of a two year pilot, avoiding a lengthy procurement process of a new IT system that would be unfeasible within the time frame. This pilot area also took into consideration the impact of the commissioning cycle and the possibility that a newly procured integrated IT system would become redundant if a new provider who operated an alternative case management system won the contract for the treatment service post-pilot.

Given the difficulties reported regarding transferring information and communication, the success of these approaches in improving integration is of key interest. Arguably, the web-based case management system offers the greatest potential for improving the flow of information across the treatment system, but delays in implementation meant that it was not fully operational during the pilot period and so its effectiveness cannot be assessed. The read-only access to community-based case management systems was felt to have had a positive impact on continuity of care, particularly by enabling prison-based staff to access DIRs completed by community staff instantaneously, thereby reducing duplication of assessment and creating a more efficient service. By stage three of the research, it was clear that where pilots had failed to find an effective solution to the integration of IT systems, this was felt to have had a negative impact on efforts to improve continuity of care.

“There was an end-to-end case management model with information technology and systems that were unable to support their role... It kind of let the worker down... They were just papered up to the hilt.”  
 (Stakeholder, Site 6, Stage 3 interview)

## Team meetings

Regular team meetings across all elements of the treatment system were identified as vital to cementing relationships and improving communication. Delivery staff spoke very positively about the impact this had on their working practices and knowledge of other elements of the system. Team building events and joint training sessions were also used to build integrated teams and improve communication.

### 3.2.5 Impacts

Of the approaches pilot areas adopted to tackle continuity of care, the creation of integrated CJS treatment systems was arguably the most ambitious, requiring the greatest change to overall treatment structures at both a strategic and delivery level. It is therefore not surprising that areas adopting such approaches reported challenges in delivering change on this scale within the two year pilot period. The extent of change to roles and working practices also meant that delivery staff felt under strain as they adapted to these new systems. Inevitably, this level of change created uncertainty and destabilised treatment systems to some extent in the short term. It is important to take this context into consideration when exploring the impacts of these approaches.

Analysis of administrative data was undertaken to explore whether pilots implementing integrated treatment systems increased the percentage of referrals from pilot prisons that were successfully picked up by the community-based CJITs. A difference in difference approach was adopted comparing pilot sites to comparison sites both pre- and during the pilot period (discussed further in Appendix C4). Table 3.1 gives the results for the three pilot areas adopting integrated community and prison-based treatment systems, setting out the proportion of service users who were successfully picked up by community CJITs within six weeks of referral from prison.

Area	2007-09		2009-11		Comparison		
	Total referrals	% Successful referrals	Total referrals	% Successful referrals	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value **
Pilot 2	73	27%	206	70%	+43%		
Comparison 2	162	20%	253	42%	+21%	+22%	0.10
Pilot 4	159	30%	262	63%	+33%		
Comparison 4	462	18%	462	35%	+17%	+16%	0.05
Pilot 6	135	6%	62	53%	+47%		
Comparison 6	146	14%	196	61%	+46%	+1%	0.38

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-1 percentage point when compared to the differences between the un-rounded figures shown.

\*\*After controlling for client characteristics.

The analysis indicates that in all three pilot areas, the proportion of referrals from pilot prisons successfully picked up in the community improved during the pilot period when compared to pre-pilot. In site 2 successful referrals rose from 27 per cent to 70 per cent, site 4 from 30 per cent to 63 per cent, and site 6 from 6 per cent to 53 per cent. When

compared to their comparison areas, the 'difference in difference' was positive in all three pilots at +22, +16 and +1 respectively. However, in two pilot areas (site 2 and site 6) the changes were found to be statistically non-significant, using a statistical model controlling for service user characteristics. While this may indicate that the pilots had no measurable impact on continuity of care, the lack of statistical significance may in part be due to the small sample sizes meaning the statistical power to detect change is low. In site 4 however, statistical modelling controlling for service users characteristics showed the improvement in the percentage of successful referrals to be statistically significant ( $p < 0.05$ ). This suggests that activity in site 4 may have had a positive impact on continuity of care.

In addition to the conclusions that can be drawn from the quantitative analysis of successful referrals, it is important to consider the views of staff and service users who participated in the qualitative interviews. Staff reported positive impacts including increased communication across the treatment system, improved understanding of different elements of the treatment journey, earlier release planning as well as some improvements to paperwork and assessment that reduced administrative burden and duplication. However, these positive impacts could be undermined if key foundations for continuity of care were not in place. These foundations were performance management structures that supported integrated teams; streamlined assessment and data monitoring processes that were consistent across the treatment system; work shadowing and joint training to facilitate communication; and integrated case management systems supported by appropriate IT infrastructure. In the case of site 4 where the quantitative analysis suggests a positive impact on continuity of care, many of these foundations were in place including prison read-only access to the community case management system, a single performance monitoring framework across the integrated service and a streamlined referral and assessment process. This pilot area also retained staff specialisms and did not rotate staff across the treatment system, suggesting that this model of integration may support improved continuity of care.

### 3.2.6 Potential for mainstream roll out

A key feature of all three areas operating an integrated treatment system was the existence of a prison within the pilot area that engaged with the aims of improving continuity of care, and most importantly held a substantial number of service users that would be released into the pilot area. However, even in these areas prisoner movement across the prison estate (both in and out of the pilot areas) continued to be a challenge to providing continuity of care. National efforts to move towards greater regionalisation in the prison system were welcomed and these changes had ensured that greater numbers of service users housed in the local prison would be released into the local area. Pilot areas also sought to address these issues by developing protocols for ensuring continuity of care in the transfer of service users to other areas, and by using "linking" staff to improve continuity for service users in prisons outside the pilot area. This is discussed later in the chapter.

In exploring the feasibility of rolling out an integrated criminal justice treatment system approach more broadly, the issue of prisoner movement and the location of prisons is key. Not all areas have a local prison serving the needs of the local population and this is a primary barrier to adopting a model of this kind. Achieving an integrated criminal justice treatment system that incorporates prison establishments in these areas requires a regional approach, large-scale partnerships and co-operation over a number of local authorities. While not impossible, the complexity of this kind of arrangement was generally thought to be beyond the scale of the current DSCPs. However, one of the integrated treatment system pilots had adopted a regional approach, creating a

partnership across three local authorities, which gives some indication that an approach of this kind is feasible.

### 3.3 Independent case manager

A second approach to improving continuity of care was the creation of an independent case manager role, designed to provide end to end case management through the CJS. This approach, trialled by one pilot, is distinct from the continuity of case manager approach already discussed, because the role did not form part of a wider integrated system. Instead, the case manager in this approach sat outside existing provision and operated independently of existing structures. As a result, the issues raised were distinct from those that arose through the continuous case management approach and so are reported separately.

In trialling this new approach, offenders with custodial sentences of less than twelve months were targeted, as evidence from the pilot area indicated this group had high levels of re-offending.

#### 3.3.1 Impact on the service user journey

Potential service users would be identified for the new service at the point of sentence via the DIP court team. Once identified, an appointment would be made in custody to introduce the service and invite voluntary participation. If willing to engage, the case manager would work with the service user while in custody to identify long-term aims and treatment needs in preparation for release, with the understanding that this relationship would continue on release. Here the case manager would act as service broker, overseeing the treatment journey with a focus on personalised support. Service users working with the continuous case manager reported accessing a wide range of services as a result of their support including mentoring, housing support, volunteering opportunities, education and training, family therapy and substitute prescribing. To improve continuity, the case manager would attend first appointments at treatment services to facilitate communication and would maintain regular contact with the service user either by phone or face to face to ensure that their needs were continuing to be met as they progressed. No limit was placed on the length of time service users could engage with the service, although the assumption was that the case manager's role would reduce as the service user progressed with treatment and engaged with a range of services.

#### 3.3.2 Integrating with existing provision

A key difference between this approach and the continuous case manager piloted in one of the integrated treatment systems, is that the independent case manager did not supersede the roles of arrest referral, CARAT or DIP workers, but instead worked alongside them. While this meant the approach did not require a wholesale restructuring of the treatment system, a key challenge has been how to implement this new approach within existing structures to complement rather than duplicate existing roles. The ability of the case manager to support the service user while in prison as well as on release, to act independently of existing structures and targets, and to place no time limit on the length of time service users could access the service were thought to be the key distinctive features that set the new approach apart from existing provision.

In common with the integrated treatment system pilots (where new structures were hampered by pre-pilot targets and data monitoring requirements), there were challenges in piloting an independent case manager role within a broader treatment system that was

not set up for a model of this kind. The move away from process-focused targets towards a more recovery-focused approach clashed with existing structures. In particular concerns were raised that the independent case manager role was potentially taking service users away from existing CARAT and DIP services, impacting negatively on their targets to engage with service users and refer them into Tier 3 services<sup>19</sup>. To resolve this issue, the approach was adapted to target service users in custody that had refused to engage with CARAT support, with the additional benefit of focussing on the hardest to reach. At the end of the two year pilot, the anticipated nationwide relaxation of CARAT targets to complete DIRs from April 2011 was expected to go some way to alleviating conflicts of this kind.

### 3.3.3 Impacts

The independent case manager role was piloted with two core aims; to improve continuity of care across the treatment system (particularly between prison and community treatment) and to support recovery through an independent and personalised approach to case management. Analysis of the percentage of successful referrals from pilot prisons to community-based CJITs provides one indicator of the extent to which the pilot was successful in improving continuity of care. Table 3.2 gives the percentage of service users who were successfully picked up by community CJITs within six weeks of referral from prison for the pilot operating the independent case manager approach:

Area	2007-09		2009-11		Comparison		
	Total referrals	% Successful referrals	Total referrals	% Successful referrals	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value **
Pilot 7	171	20%	175	47%	+28%		
Comparison 7	332	25%	359	33%	+7%	+20%	0.01

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-1 percentage point when compared to the differences between the un-rounded figures shown.

\*\*After controlling for client characteristics.

The table shows that the proportion of service users successfully referred to CJIT after leaving prison increased from 20 per cent pre-pilot to 47 per cent during the pilot period. In the comparison area successful referrals also increased but to a lesser extent, from 25 per cent to 33 per cent.

Evaluating these changes using a difference in difference approach (discussed further in Appendix C4) shows an improvement of 27 percentage points in site 7, against an 8 point improvement in the comparison area, a difference (in differences) of +20 percentage points. Statistical modelling of this change, controlling for service user characteristics, showed this improvement to be statistically significant ( $p < 0.01$ ). These results therefore suggest that the pilot may have helped to improve the rate of successful referrals. However, caution must be taken in attributing this improvement solely to the independent case manager role as this was just one element of this pilot and was developed on a small scale during the pilot period. Other elements of pilot activity

<sup>19</sup> Tier 3 provision is defined as structured community-based care planned drug treatment services including structured day programmes. Tier 2 treatment is defined as open access services that provide advice and guidance, harm reduction, drop in, triage and referral to Tier 3 provision (NTA, 2006).

including the development of a consortium of providers to encourage partnership working may also have contributed to the increase in referrals.

From the qualitative interviews with staff and service users a range of factors were identified that were felt to lead to improved outcomes. In particular, the personalised nature of the approach was felt to improve service user engagement by ensuring that the services offered met their needs. Brokering services and facilitating communication across a range of support was also thought to reduce the burden on service users of negotiating the system and this was considered a key facilitator to positive outcomes.

“She comes to my Social Service meetings and... any meeting that I have, she’ll come and she’ll coordinate and she’ll... get people on board that need to work with me and... it means I don’t have to do it because I’m not capable of doing it, so it means things happen... things just seem to move forward rather than going round in a circle... I just have to concentrate on getting well.”

(Service user, Site 7, Stage 2 interview)

An outcome-focused approach where their goals and needs were the focus of the support received was also viewed as critical by service users who described the process of setting objectives for their recovery and being supported to make their own choices as key to their engagement and success.

“Everything [the independent case manager] suggested or pointed me towards I’ve looked at, but I’ve picked out the best out of each, so its me that’s chosen the path that I’ve taken... She doesn’t force anything on you. Everything is open to suggestion.”

(Service user, Site 7, Stage 3 interview)

In the long-term the pilot wanted to see reductions in re-offending rates and successful recovery from drug dependency. However, these outcomes would only become apparent over a longer time period, beyond the scope of this evaluation.

### 3.3.4 Post-pilot plans

Post-pilot the intention was to roll out the independent case manager role to a larger team of staff who previously worked as a DIP through-care team, changing the scope of this team from a Tier 2 service to a Tier 3 service. Consistent with the role during the pilot period the emphasis was envisaged to be on a “*case manager as broker*” model, with a focus on the service user’s overall recovery as a key feature of the service going forward.

## 3.4 Embedded CJS treatment provision

A third approach to increasing continuity of care, adopted in one pilot area, was to merge DIP and DRR and so embed criminal justice provision within non-CJS treatment services. The historical separation of DIP and DRR funding in the area had created a two tier system in which service users had access to different provision depending on their status as a voluntary DIP service user or as subject to a DRR. This distinction had implications for continuity of care as service users that had been engaging with DIP services prior to receiving a DRR would find that they no longer had access to the same provision including outreach support and a DIP caseworker. By utilising a freedom and flexibility request to combine DIP and DRR funding, the pilot was able to amalgamate these services to provide a consistent range of support for all CJS service users with the hope that this would improve the consistency of provision and improve successful completion of DRRs.

As well as combining DIP and DRR provision, the pilot also took the opportunity to embed the CJS team within community treatment services, supported by an integrated management structure. Historically CJS provision had been based in one geographical location and separate from community treatment services; a distinction that was thought to contribute to a number of barriers to continuity of care and effective treatment including poor communication between staff and a lack of awareness of what provision was available for service users. It was also thought that the transition between CJS services involving proactive outreach support and non-CJS structured treatment was too big for many service users to negotiate successfully. By embedding CJS services within community treatment, the intention was to make the transition less daunting and consequently more likely to succeed. The new structure also facilitated improved partnerships with the probation service who used the treatment premises to meet their service users, further improving engagement with DRR orders.

A major facilitator to implementing this new structure was the fact that DIP services and community treatment already fell under a single provider. As a result, the restructure did not require any form of re-commissioning or consortium arrangement. The restructure also enabled the pilot to open an additional treatment service in what had previously been the DIP office, improving the geographical spread of treatment services across the pilot area.

### 3.4.1 Impacts

Staff identified a range of impacts from the co-location of CJS teams with community treatment services. The greater geographical spread of CJS services was thought to have improved access and ensured that services could be more responsive to local need. In addition, service users spoke positively about having access to DIP services within local offices as the cost and time involved in travelling to services located further away was a barrier to engaging with treatment. Having services in one place as well as access to probation staff was particularly valued by those on DRRs who felt this facilitated compliance with their order. There seemed to be a good knowledge amongst those interviewed of the range of services available at their local treatment service, indicating that the pilot's aim to break down barriers between CJS and community-based treatment by co-locating them was indeed raising awareness of what was available and facilitating that transition.

Staff also reported positive impacts for themselves professionally, in terms of facilitating communication, raising their awareness of the options available to service users, increasing their opportunities for training and development, and enabling them to do more structured work to prepare service users for mainstream treatment. In embedding CJS services in local offices, staff also reported cost and time efficiencies by ensuring outreach workers were more locally based, reducing the need for lengthy journeys to meet service users.

Analysis of the number of referrals made from the community-based CJITs into the broader treatment system may be used as one indicator of the extent to which the pilot was successful in improving continuity of care. Table 3.3 shows the number of referrals pre-pilot (over a 15 month period from December 2007 to February 2009) compared to the number during the pilot period (December 2009 to February 2011), and the proportion of these referrals that were successfully picked up by the community treatment service.

**Table 3.3 Continuity of care (CJIT to community) in ‘embedded CJS provision’ pilot \***

Area	2007-09		2009-11		Comparison		
	Total referrals	% Triaged within 6 wks of referral	Total referrals	% Triaged within 6 wks of referral	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value
<b>Pilot 5</b>	200	35%	423	29%	-6%		
<b>Comparison 5</b>	237	50%	395	59%	+9%	-14%	0.012

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-1 percentage point when compared to the differences between the un-rounded figures shown.

The table shows that in the pilot area co-locating CJS and community treatment the number of service users referred from CJS services to community treatment rose from 200 pre-pilot to 423 during the pilot, an increase of 112 per cent. In the comparison area the number of referrals also increased but to a lesser degree, from 237 to 396, an increase of 67 per cent. This increase in the number of referrals would appear to support the view that co-locating CJS and community treatment staff led to an increased number of service users being referred to community treatment services.

Where the impact is less clear is in the number of these referrals that were successfully triaged within six weeks of referral. The successful triage rate dropped from 35 per cent pre-pilot to 29 per cent during the pilot. In the comparison area the successful triage rate increased from 50 per cent to 59 per cent. Evaluating these changes using a difference in difference approach (discussed further in Appendix C4) shows a difference (in differences) of -14 percentage points. Statistical modelling of this change showed it to be statistically significant ( $p < 0.01$ ). These results suggest that the pilot had a negative impact on the percentage of service users successfully triaged, although in real terms the number of service users successfully triaged within six weeks increased. While it is difficult to say with any certainty what caused this decline in the percentage of service users successfully triaged within six weeks, one possible reason may be that the increase in referrals created capacity difficulties for the community practitioners.

### 3.4.2 Post-pilot plans

In light of positive feedback from staff and service users in relation to improving the geographical spread of services and improving communication between criminal justice and community-based treatment services, the intention post-pilot was to continue with co-location of CJS and community treatment teams.

## 3.5 Continuity via linking roles

The final approach to improving continuity of care within CJS treatment involved targeting the vulnerable point in the treatment journey between custody and the community where services historically failed to join up and service users were at risk of disengaging. A number of pilots incorporated provision of this kind into their treatment systems, designed to complement and support other continuity of care measures. The aim was to increase retention in treatment on release from custody, and one form this took was offering through the gate support by taking service users to their first community appointments on release.

One area facilitated this approach by restructuring staff that had previously performed prison in-reach and community outreach into a team that worked across the treatment system. This team was embedded within local criminal justice treatment teams, where previously they had been based separately. The new approach was felt to ensure strong communication between practitioners, improving continuity for service users. Where previously, the team had worked across the whole pilot area, the new approach facilitated a geographical division of cases, reducing the amount of time and money spent travelling, and enabling staff in this role to build up a close working relationship with their community team. By utilising and restructuring existing resources to provide this service, this approach had the additional benefit of being sustainable in the long-term, requiring no additional funding.

An alternative model for this form of support involved contracting a third sector organisation that provided volunteers offering mentoring, through the gate support and ongoing support in the community upon release. The impartiality of the third sector organisation was seen as facilitating service user engagement combined with the fact that it offered a range of support, from a “*listening ear*” through to support with benefits and housing. The service, which was partially supported by pilot funding, was also thought to add capacity to existing provision, providing additional support to service users.

### 3.5.1 Impacts

In assessing the impacts of the forms of linking role described here, it is important to acknowledge that this provision was often supplementary to other measures pilot areas adopted to improve continuity of care. In one pilot for example, this approach was delivered within an integrated criminal justice treatment system, while in another, the model was adopted alongside co-locating criminal justice teams within the wider community provision. Because of its supplementary nature it is not possible to tease out the impact of these approaches from the administrative data.

However, drawing on the views of staff and service users a key strength of this approach was that it provided support at the most vulnerable points in a service user’s treatment journey. Unlike integrated treatment systems, that by their nature are confined to creating integrated provision with a local prison, this kind of provision is flexible enough to provide support to service users across the prison estate, with linking staff/volunteers regularly travelling to prisons outside the locality to work with service users. Where service users had experienced this kind of provision, the value of having initial contact in prison which was later followed up on release was viewed very positively.

“He came out to the flat... I didn’t think I’d ever see him again. I thought he was just one of them people that come and say their bit and then that’s all you see, cos a lot of people do that in jail. They’ll come and just talk to you, but they just seem to do it while you’re in there. But he’d come, and he’d made an effort... made [my girlfriend] listen to what he had to say. Got her an appointment, and within a few weeks he got her on a script. He did all of that, and he kept to his word.”

(Service user, Site 4, Stage 2 interview)

It is clear that provision was having a positive impact on engagement for some service users. However, critical to the success of this form of support was good communication and flow of information across the system to ensure that staff performing this role were equipped with up to date information on prison movements and transfers.

### 3.5.2 Post-pilot plans

Of the two approaches to linking roles described here, the model that restructured existing in-reach and community outreach staff to perform this role was felt to be sustainable long-term as it did not require additional funding. As such, the approach was set to continue post-pilot. The model that contracted a third sector organisation was partially funded by the pilot and therefore concerns were raised about its sustainability. However, by the end of the pilot period local funding was used to secure the service for an additional year post-pilot.

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## 4 System Changes: Personalisation

Delivering a personalised treatment system was a priority for a number of the DSCPs, enabling service users to access the most appropriate interventions for their individual needs rather than being restricted to a set menu of services. In the field of social care, the Department of Health (DH) define personalisation as being a system where “every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings” (DH, 2008).

Two different approaches to personalisation were implemented across the DSCPs; self-directed support (SDS), and a single point of assessment (SPA). This chapter will explore how these two approaches were implemented and experienced within the pilot sites along with a discussion of their impacts.

### 4.1 Self-directed support

SDS builds upon the core aims of personalisation by enabling service users to choose which services and activities to access. Previous research has shown the importance of service user choice in both engagement with treatment and treatment outcomes (Fischer et al., 2007; Stevens et al., 2007). SDS is built upon the premise that service users themselves have most knowledge about their own needs and in collaboration with professionals, will identify the most appropriate interventions to address them.

“The client, they’re the expert in their own care needs... so to work with that I think that’s really important. The aim’s for them to get the services that they feel as appropriate for their own needs.”

(Delivery staff, Site 1, Stage 2 interview)

The service user is therefore put at the heart of their treatment journey, as they are through the promotion of patient choice within the NHS and other health and social care services. Through SDS, service users have access to a range of services and provisions which can increase their recovery capital<sup>20</sup>. Services accessed by service users included health and leisure activities, criminal records bureau (CRB) checks, travel warrants and passes, and education and training opportunities. SDS had also led to the purchase of tools and equipment for employment and to facilitate learning.

#### 4.1.1 Activity

SDS was implemented in two of the pilot sites. One embedded SDS into Tier 3 care coordination services. These were delivered by one provider through four geographically dispersed teams across the pilot site. The pilot project manager led on the delivery of SDS within this site. Changes made in this site to facilitate SDS were:

- The identification of SDS leads within each of the four teams to promote SDS within their service. They were required to attend meetings with the SDS project

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<sup>20</sup> Defined in the 2010 Drug Strategy as “the resources necessary to start, and sustain recovery from drug and alcohol dependence” and can be categorised into social, physical, human and cultural capital (HM Government, 2010).

manager, focussing on the roll out and operation of SDS and assist both colleagues and service users to engage effectively with it.

- The introduction of a service broker to work alongside care coordinators<sup>21</sup> to source provision for the service users. The service broker was also responsible for the invoicing arrangements when service users accessed a service which did not come from the block contracted providers.

The other site offered SDS alongside traditional treatment services due to introducing SDS later on in their pilot. Here a specific SDS project manager was responsible for the promotion of SDS and assisting care coordinators in accessing SDS for service users. Neither site made changes to the commissioning of their services to deliver SDS and as such did not require any freedoms and flexibilities to be granted from the national project board.

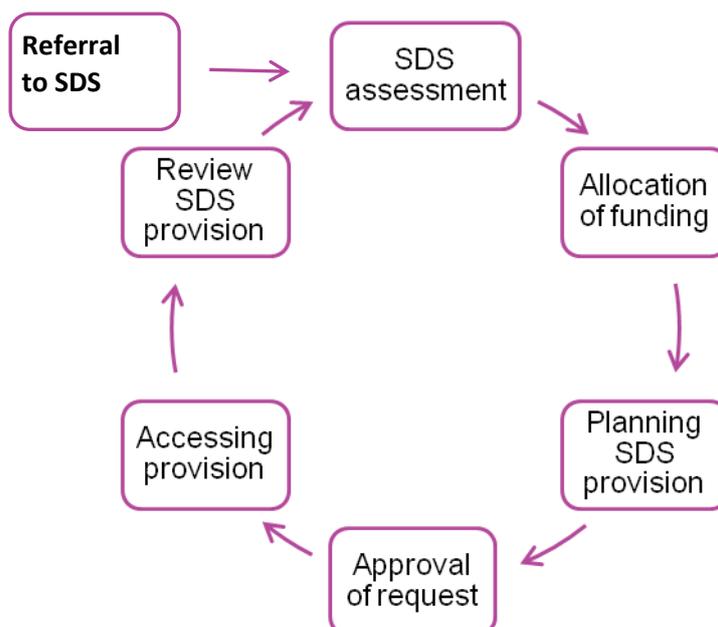
### 4.1.2 Funding SDS pilots

Both SDS sites utilised pilot funding to pay for the services not currently commissioned within their block contracts such as structured day programmes and substance misuse counselling. Mainstream funding was utilised for accessing education, employment and health provision, for example, health budgets could be used to fund gym passes while education courses could be funded through adult learning services and colleges. The sustainability of this approach is discussed later in the chapter.

### 4.1.3 Service user journey

The diagram below shows the service user journey through SDS. This section then goes on to explore each stage of the journey, identifying the key differences between the two sites along with a discussion of their strengths and the challenges faced.

Figure 4.1 SDS service user journey



<sup>21</sup> A care coordinator is a named professional who will engage with the service user and support them throughout their care plan.

## Referral into SDS

In both sites care coordinators were responsible for referring service users from their caseloads into SDS. Service users were selected because they were either viewed by their care coordinator as able to make effective decisions around their treatment or targeted because of certain characteristics. The table below shows the groups prioritised in each of the sites.

	<b>Prioritisation Criteria</b>
<b>Site 1</b>	<ul style="list-style-type: none"> <li>• Females</li> <li>• BME groups</li> <li>• Involvement with CJS</li> <li>• Stimulant users</li> </ul>
<b>Site 7</b>	<ul style="list-style-type: none"> <li>• In contact with independent CJS case manager</li> <li>• Accessing DIP provision</li> <li>• Sex workers</li> <li>• In treatment for over four years</li> <li>• Hard to engage service users</li> </ul>

These groups were chosen as they were identified as being the hardest to reach and engage in traditional treatment services. The sites also wanted to pilot SDS with a variety of service users at different levels of stability and stages in treatment to see how it would work for service users were it to be rolled out beyond the pilot.

The way in which service users were recruited into SDS varied between the sites and this impacted on the number of users receiving services through SDS. Take up from 60 service users was the target for the SDS pilot in one area, and this was achieved as any service users who dropped out were immediately replaced. The other SDS pilot intended to recruit as many service users into SDS as possible, but only 45 service users were recruited and there was no system in place to immediately replace those who exited. Staff were reportedly reluctant to refer service users to SDS early on in the pilot due to concerns that service users would not make the most appropriate decisions for themselves. By not referring service users into SDS these risks were felt to be managed.

*“I think people struggled with the notion of how it would actually work in substance misuse and that was I think part of the challenge, how it was going to be seen to be used wisely, this money and what options people did have and how they were going to link those back to treatment needs.”*

*(Delivery manager, Site 1, Stage 2 interview)*

Work was therefore undertaken by both the project manager and the SDS leads within each team to promote SDS. This included training to inform service staff about SDS and how to access services through SDS. Some care coordinators felt more confident referring service users to SDS as a result of the training and able to think innovatively about what services would be therapeutically beneficial for services beyond traditional drug treatment services.

*“It’s instilled a little bit more confidence in practice nurses to not be so risk averse and to challenge each other on what will be risky for purchase and what makes sense, because it relates back to outcomes.”*

*(Delivery staff, Site 7, Stage 3 interview)*

Beyond these early challenges, the profile of service users and referrals to SDS continued to be affected by three factors.

- **Staff pre-selection**

There was concern that staff were not following the “*test then request*” model when referring service users into SDS. Rather than referring a service user to SDS then assessing their needs, it was thought that care coordinators referred service users after already identifying a service or resource that they would benefit from.

- **Low need service users**

Staff reported that service users selected for SDS were of comparatively lower need than the wider treatment population. Staff were reluctant to use SDS with high need service users due to perceptions that the referral process would be more time consuming than for traditional treatment and that the type of intensive treatment these service users needed was not readily available through SDS. In order to address these concerns the project manager in one of the sites had developed an example SDS care plan for a high need service user, using community services instead of a residential rehabilitation programme. While this was perceived to have resulted in a small number of packages for high need service users being requested, this was not widespread.

Staff also reported that service users engaged in SDS were nearing the end of their treatment journey, usually stable on a substitute prescription or not using any substances. The services accessed therefore were generally to facilitate employment. Service users themselves spoke of SDS giving them the motivation to no longer rely on substitute medication as described by this service user.

“I think it’s a good idea, giving people the opportunity. Maybe a lot of people just need motivation and that bit of encouragement to get out of that cycle of being on medication for years.”

(Service user, Site 7, Stage 3 interview)

In order for SDS to be rolled out more widely it would need to be taken up by service users with a higher level of need.

- **Service user reluctance**

Despite previous research showing the importance of service user choice in engagement with treatment (Fischer et al., 2007; Stevens et al., 2007), staff felt that service users were apprehensive about utilising SDS. They were not accustomed to having choice in the services they accessed and did not necessarily feel that it was appropriate for them to be making these decisions. To this end a DVD was planned to provide additional information on SDS for the wider service user population.

“We’re looking at actually changing the hearts and minds of service users because some of them are like, ‘I don’t want to do this. I just want to come and get my script...’ So we’ve got to change their minds and we’ve got to increase their confidence in asking for things that are realistically going to meet their needs.”

(Stakeholder, Site 1, Stage 2 interview)

## SDS assessment

Upon being referred into the SDS programme both sites undertook a SDS specific assessment, in addition to the standard comprehensive assessment tool used for all service users in the pilot sites. The assessment covered the service user’s substance misuse alongside questions around personal care needs, housing, leisure and community needs, education, training and employment (ETE) needs and family and social networks. The assessments used in both sites were developed over the pilot

period with one site developing their own bespoke assessment tool while the other used the pre-existing *Recovery Web* tool.

In deciding on their eventual assessment tools a number of factors were taken into account. **Usability** of the tool was crucial. The original SDS assessment used in one site was designed to be completed by the service user. However, service users struggled with the form and often sought the assistance of their care coordinator to complete it. Staff felt that SDS assessment tools should also allow for discussion and empower services users to make choices for themselves and think beyond traditional drug treatment services, where as the original SDS assessments were felt to be dominated by tick boxes and therefore suppressed such discussion.

“When you’re going tick boxes, people start to phase out a bit. But when they’re discussing themselves and looking where they are and their progress and what their strengths are people get engaged and start leaning forward, excited.”

(Delivery staff, Site 7, Stage 3 focus group)

The **length** of the assessment was also a key factor, with the original assessment seen by both service users and delivery staff to be long, unwieldy and repetitive, especially after the completion of the standard comprehensive assessment. Assessment tools also needed to ask for **relevant** information; the initial assessment and some of the questions asked were thought to be irrelevant to a person’s substance misuse, particularly those around practical elements of daily living and meeting personal care needs.

“Some of the questions they asked you, like ‘Can you wash and clean yourself?’ and ‘Can you do this yourself?’ and for me I found it was a bit silly... I really didn’t know what way to answer it, ‘cos I am quite a clean person, looked after myself, but I still needed support around, I wanted to access agencies and support groups like NA.”

(Service user, Site 1, Stage 2 interview)

Staff reported that improvements made to the assessment tool had increased its usability and resulted in an increase in staff referrals to SDS. Both sites were also looking to incorporate SDS elements into their standard comprehensive assessment in order to further integrate SDS into their treatment system.

## Allocation of funding

Two approaches were taken to the allocation of funding within the SDS pilot sites; allocating a flat rate to each service user or allocating funding based on assessed need. Each of these approaches is discussed in turn.

A Resource Allocation System (RAS) was used to **allocate funding to service users based on assessed need**. The RAS had five bands with need defined by the following categories; critical, substantial, medium, minimal and very low need, which were classified as A-E. Each of these bands had an associated funding allocation<sup>22</sup>, apart from ‘very low need’ where there was no funding allocated. The funding ranges were based upon the Models of Care (NTA, 2006) and how much it would cost for a service user to access the appropriate services through traditional funding systems. Funds were allocated on a weekly basis and could be used to access a broad range of services including those which would otherwise not be funded through traditional routes.

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<sup>22</sup> The funding allocations were as follows: Band A £550-650 a week, Band B £200-250 a week, Band C £50-100 a week, Band D £25-40 a week and Band E no funding.

Where the RAS was utilised the average weekly allocation was reportedly £100, although those with greater need accessed up to £600 a week. In line with the ethos of SDS service users were aware of how much funding they had been allocated<sup>23</sup>. There was concern amongst some staff that this would lead to service users applying for more expensive services than they required in order to use their full allocation. However, this was not the case and there had been no change in how much of the allocation was utilised or the types of services accessed through SDS when service users were aware of the funding allocated to them.

The other approach was a **flat rate allocation**, allowing each service user a maximum of £1,000 which they could use to purchase additional services based on need. Service users were not aware of the amount of money available to them; staff queried this and reflected that not informing them went against the ethos of personalisation. Staff reported that service users had asked how much they were entitled to. Despite the allocation of £1,000 per service user most provision had reportedly cost around £100 at the time of the research. This site decided against setting up a formal RAS due to there not being enough time to implement it in the remaining pilot period; instead they wanted to test personalisation and intended to put something in place for future roll out.

## Planning SDS provision

Decisions around what to use the allocated SDS funding for were based on discussions between service users and care coordinators and included in care plans along with identification of the intended outcome(s). The decision to integrate SDS services within care plans was made in order to reduce the administrative burden which could be generated by an additional planning system and ultimately delay service users from accessing services. In keeping with the ethos of SDS there was no definitive list of services that could be accessed, partly because the intention was that service users within SDS were able to access any service that would be of therapeutic value to them. However, this meant that when planning provision there was uncertainty from both service users and delivery staff about what SDS could be used to fund.

“My staff team are quite often asking [staff member] and myself about things because they don’t really have an awareness of what... is appropriate, ‘Is this going to go through?’ ‘What do I write to put it to panel?’ ‘How do I sell the case?’”

(Delivery staff, Site 1, Stage 2 interview)

## Approval of request

Once SDS provision had been planned, the approval was approached in two ways: one site had set up a learning and approval panel to respond to SDS requests, the other required line manager authorisation.

The **learning and approval panel** included the service manager, the SDS project manager, SDS leads from within the services and the service broker. All members were invited to comment (over secure e-mail) on requests based on their therapeutic value to the service user. Services could either be approved for SDS or the panel could request more information to establish if the services contained within the action plan met the assessed needs and treatment outcomes. Where requests were felt not to be appropriate for SDS funding alternative sources of funding could be sought by the service broker. The panel had streamlined the approval process over the pilot period

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<sup>23</sup> In Control, a charity which pioneered personalisation within adult social care, state that in order for service users to make choices about their treatment they must know how much money they are entitled to (In Control, 2011).

which meant that decisions were made within one week and care coordinators knew when approval would be granted and services could be accessed.

However, there was uncertainty about who had final sign off of requests. There was also concern that approval lay with the service manager who was removed from working with service users on the ground.

“When it goes further up the chain, you lose that empathy... and that working with somebody... chaotic might mean one thing to someone up there and one thing to us down here... For someone else to go, ‘Yes, actually that’s not right’, when everyone else has gone, ‘We think it is’. It’s a bit disappointing for us as a team I think.”

(Delivery staff, Site 1, Stage 2 focus group)

The panel also had the additional function of acting as a learning resource to promote awareness of the range of therapeutic treatment options which could be accessed through SDS. SDS staff felt they benefitted from this aspect of the panel, in terms of having the opportunity to discuss applications and how they would be of value to the service user.

The other approach to approval of requests was **line manager sign off**. Challenges facing this approach included no clear time frame in which decisions had to be made meaning that service users could experience delays accessing their provision, which in turn could lead to service users dropping out of SDS. There was concern amongst staff that involvement in SDS could have a negative impact on service users’ engagement with treatment due to initial empowerment being undermined by delays or not being able to access preferred treatment choices.

“I had to wait for my music studio to go back in my room and I were like, ‘I need it now’. I could’ve gone and lapsed on that because I were that stressed out at the time because it were like months and months... They’ve just dangled a carrot and now they’re not even going to give me ‘owt.’”

(Service user, Site 7, Stage 3 interview)

In addition, this approach did not have the same potential for staff learning as the learning and approval panel, as decisions would be made solely by line managers without discussion with staff. Within this site a more formal approach to approval of requests was required in order to cope with increased demand.

## Accessing provision

This section details the processes for accessing services through SDS and covers the role of the service broker in sourcing provision, invoicing processes and their implications for delivery, the role of buyer groups and how the provider market has been stimulated to facilitate the delivery of services through SDS.

### Service broker

Given the austere economic climate the pilots were operating in, it was crucial that the SDS services accessed by service users offered value for money. Service users and staff were involved in researching not only where they could access a service but also provision that was competitively priced. One of the SDS pilots employed a service broker early on in the pilot to assist service users in sourcing the most appropriate service for their needs. The service broker was seen as a valuable member of the SDS team, meaning that care coordinators did not need to deal with more administrative tasks and could spend as much time with service users as possible.

“They’ve [the service broker] been crucial actually because practitioners don’t have time realistically to go and identify all these different things, all these different providers that could be out there, that’s a massive task, it’s a much bigger piece of work than any practitioner would have time to do I think... The broker’s been a god send really.”

(Delivery manager, Site 1, Stage 2 focus group)

The broker was located at each of the four offices for one day a week, leading to increased partnership working between the service broker and the care coordinators. However, for wider roll out, it was felt that a dedicated service broker would be needed for each team as they had struggled to support over 20 service users at a time. The importance of the broker was highlighted in stage three of the research where staff reflected how referrals to SDS had declined since the broker had left at the end of the pilot. In the site where a service broker had not been employed as part of the SDS pilot, staff had difficulty sourcing SDS provision alongside their case work.

### Invoicing

Service brokers also played a key role in the invoicing for SDS services. This was valued by staff as invoicing had proved challenging in both sites. Many of the services that SDS service users were accessing were unaccustomed to receiving payments from third parties. Invoicing was especially complex when working with statutory providers compared to voluntary agencies who already had formal invoicing procedures in place. Where formal procedures were not established, delays in accessing provision had led to staff purchasing items such as travel passes for the service user and then invoicing the service themselves. Delays in access could result in service users missing out on a particular service or disengaging from treatment entirely.

“It’s almost like they’ve got this little honey pot and it’s been taken away... they’ve gone through this assessment, they’ve said you’re eligible for this and it’s gonna meet your need and they’ve worked really hard to identify everything and then they’re twiddling their thumbs waiting for it to happen.”

(Delivery staff, Site 1, Stage 2 focus group)

The frustration of delays was exacerbated for some service users because they were not kept fully informed about them and what was causing them.

“Just kept getting told, ‘It’s down to them. [Name of staff]’s not in,’ or, ‘She’s off sick,’ or whatever. You know? I was just left to my own devices. Would have been nice to have known what sort of direction it was going.”

(Service user, Site 1, Stage 2 interview)

Staff suggested direct payments<sup>24</sup> as one way to mitigate these issues, where service users would purchase their own services. However, service users were not receptive to having this level of responsibility and so setting up direct payments was not pursued during the pilot. However, had they been introduced, a freedom and flexibility would be required to overcome the barriers that prevent drug users receiving direct payments within health and social care services<sup>25</sup>. Pre-paid cards were suggested as an alternative to direct payments; these could be “loaded” with the funds the service user had been allocated. The service user could then purchase services and return the receipts to their case worker.

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<sup>24</sup> Direct payments are cash payments given to service users in lieu of services they have been assessed as needing, and are intended to give users greater choice in their care.

<sup>25</sup> Direct payments of this kind are currently being explored in one local area outside of the DSCPs (Croydon DAAT, 2012).

## Buyer groups

A desired outcome from one pilot was the development of buyer groups, where service users would combine to commission their own services, such as a group counselling session or an art course for example. The pilot project manager had been heavily involved in the set up of some early buyer groups as a demonstration of how they could be used but their use was not widespread at stage three of the research. Limited progress was attributed to there not being enough service users accessing the same service or provision for this to be necessary or feasible.

## Market stimulation

In order for SDS to be widely accessed it was necessary for providers to adjust their traditional delivery models to accommodate and meet individual need. For example, one provider adapted their delivery by allowing an SDS service user to access their structured day programme through a new day rate, which allowed the service user to also attend a full time photography course. It was felt that the service user benefitted from this package of support.

*“He was supported as much as he needed to be supported because he had somewhere to go each day. For this treatment to be effective, an art college or a gym pass isn’t going to do... If it’s really going to be effective you need a full support package which is what that was and it was sort of affordable.”*

*(Delivery staff, Site 1, Stage 3 focus group)*

One site made early attempts to inform providers about the aims of SDS and how they could adapt their service to be incorporated into SDS. However staff in both sites reported that providers were slow to come on board with personalisation until they had seen positive impacts. Delays in engaging providers was also felt to be a consequence of changes in project management during the early stages of the pilot which resulted in a lack of clarity about the aims of SDS. Later on in the pilot an event was held to stimulate provider interest. Those involved with the pilot felt that this had been well received by the providers in the area and was anticipated to lead some more personalised provision.

## Review process

Regular reviews of treatment gains are an essential part of drug treatment (Strang, 2011). Two different approaches to the review process were evident across the two sites.

### Reviews

The sites which implemented SDS undertook reviews at different times in the service user treatment journey; in one area they were undertaken at six weeks while in the other they were every four weeks. Reviews were conducted to ensure that the services accessed were addressing service users’ substance misuse issues and were undertaken using the same SDS assessment tools initially used. Staff sometimes struggled to conduct these reviews because appointments with service users were for a limited time and SDS provision was not always seen as a priority if the service user presented in crisis.

In the site operating a flat-rate budget allocation, the review was also an opportunity to identify any additional treatment needs that the service user might have. If additional needs were identified the remainder of the £1,000 allocation could be used to provide appropriate services. At the time of the stage three research no one had exited SDS and staff were unsure about how this would happen given that service users were allocated a set amount of money and not an allocation over a time period.

## Reassessment

In the site where the level of funding was dependent on a needs analysis a reassessment would take place at 12 weeks. If the level of funding that the service user was entitled to had remained the same, they would be able to continue accessing the same SDS provision. However if the service user's needs had changed, and correspondingly, the level of funding they were entitled to, they would be required to select provision which met their needs and the process of approval would be repeated. Concerns were raised that a reassessment and subsequent reduction in funding could prevent further recovery and reintegration, with service users prevented from accessing the very service which had been so beneficial for them.

*“We’ve got one [service user] who’s been having long-term counselling and I think he’s had it for about six months now and this was when he applied for it... His key worker’s now been told that he’s got to reassess him which means going back through the self-assessment questionnaire and then seeing what his allocation is and obviously there is improvement for him and I think the fear is that this person is going to come out at band D and, therefore, his counselling will cease.”*

*(Delivery staff, Site 1, Stage 2 focus group)*

Following the reassessment service users could also come out at a low level need (which would not equate to any funding) in which case they would exit SDS.

### 4.1.4 Impacts

This section explores the impact of SDS on service users before going on to explore its impact on the treatment system more broadly.

#### Service users

In discussing the impacts of SDS on service users it is important to acknowledge that SDS had been piloted with just over 100 service users and so it is not possible to discuss how these impacts may apply to the wider substance misuse population. Also, given the role of care coordinators in the selection of service users (discussed earlier in the chapter), it is possible that service users had been specifically selected for SDS and so would have had the greatest potential for positive impacts.

Notwithstanding these considerations, there was a sense from stakeholders, delivery staff and service users in the pilot sites that personalised services accessed through SDS led to a greater chance of recovery for individuals and increased recovery capital, compared to the services they would have traditionally accessed through the main treatment system. The research identified a range of impacts for SDS all of which would assist a service user on their road to recovery.

#### Substance misuse

Service users reported progress in their attempts to combat their substance misuse, whether reducing their use of illicit drugs or their substitute medication prescription. SDS had enabled them to access services that they thought would benefit them the most and move away from services which they had accessed in the past, such as counselling or structured day programmes, which they did not find as valuable.

*“The bonus was it was something I enjoy and I’ve got a passion for and... I’ve done day programmes and things like that... so I didn’t need that. It was great, something that I had passion for and something that I gained a lot from confidence wise... Going to a group... at that moment in time wasn’t what I needed.”*

*(Service user, Site 1, Stage 2 interview)*

Having access to leisure activities was seen by service users to improve their chances of recovery as it focussed their minds on an activity and brought an element of routine and structure to their lives which they may have lacked in the past. Having a routine was thought by both staff and service users to aid reduced drug use by eliminating boredom. Activities could also motivate service users to achieve specific goals such as completing an ETE course, which in turn could help to reduce their drug use.

“I think it’s giving the client the opportunity to take charge of their care or meet their needs, which has given them structure to the day and taken them away from the drug use, but it particularly applies to those that are very motivated and keen to get away from the drug culture, so something like a fishing licence has given that. That was an interest the guy’s had for a long time.”

(Delivery staff, Site 1, Stage 2 interview)

## Health

Along with the primary health benefits of reduced illicit drug use, activities such as gym passes and fitness equipment accessed through SDS also led to improved physical health, which in turn was felt to lead to other positive impacts such as increased engagement with ETE opportunities. SDS also allowed service users to impact on their mental health via access to specific forms of counselling such as Acceptance and Commitment Therapy (ACT)<sup>26</sup> or sexual violence and domestic abuse counselling in order to tackle the underlying causes of their substance misuse, rather than being restricted to specific drug counselling and support.

## Self-efficacy and responsibility

Taking responsibility for their own treatment journeys and making decisions about what services they would benefit from led to a greater sense of self-efficacy amongst SDS service users. Accessing employment-related resources such as educational courses or the purchase of work tools was seen as a step towards employment which would add stability and purpose to their lives along with increasing their self-confidence. In addition, service users who were involved in sourcing their own provision demonstrated responsibility in sourcing the most cost effective and appropriate services.

“She [care coordinator] seems to let me direct it, just guides me in the right direction... but my say is the final say in things, and if I mess up, its on my toes.”

(Service user, Site 7, Stage 3 interview)

## Social impacts

Service users attributed improved family relationships to SDS. It gave them the opportunity to spend time with children and other family members, either through providing the funding for travel to see family or being able to undertake leisure activities with them. This in turn had impacted on one service user’s criminal activity as they no longer felt it necessary to commit crime in order to fund activities with their family.

“Just being able to take my son out and do stuff really, it meant the world. It meant me not reoffending to get money so that I could do these things with my son.”

(Service user, Site 7, Stage 3 interview)

Service users also welcomed the opportunities that SDS gave them in socialising and building relationships with members of the community who did not have substance misuse issues. Such opportunities arose through accessing mainstream educational

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<sup>26</sup> ACT is a cognitive behavioural method of psychology that emphasises processes such as mindfulness and acceptance in helping individuals overcome the obstacles in their lives.

courses, undertaking voluntary work or through engaging in leisure activities instead of attending mainstream drug services.

“Lots of people have gone to mainstream colleges or night classes and gyms... Where they’re accessing normal services they’re meeting new friends which aren’t part of the drug culture, which is one of the most significant things.”

(Stakeholder, Site 1, Stage 3 interview)

## Treatment system

SDS has also had a number of impacts on the treatment system as a whole.

### Care planning

SDS meant that care coordinators now assessed the wider needs of service users, such as issues related to work and employment. There was also a renewed focus on care planning being more outcome-focussed and meeting individual needs.

### Access to mainstream services

Although some were already available to service users, SDS had facilitated greater access to mainstream services, such as ETE training funded through both the local authority and other agencies.

### Cost efficiencies

Positive perceptions of SDS meant that stakeholders believed it had the potential to lead to cost efficiencies in the treatment system by enabling more people to effectively exit rather than remaining in treatment.

## 4.2 Single point of assessment

The second way in which personalisation was approached was through the set up of a single point of assessment (SPA), building upon the core aims of personalisation by facilitating greater access to appropriate services, whether drug treatment or mainstream services. The SPA did this through the completion of a comprehensive assessment covering all needs within drug use and health and social care, and then onward referral to the appropriate services. While service users continued to access the same menu of pre-commissioned services, the intention of the SPA was to assess the needs of service users holistically and improve access to a wider range of mainstream services. The SPA was similar in design and ethos to the Local Area Single Assessment and Referral System (LASARS) which will form a central part of the Drug and Alcohol Recovery PbR pilots in providing initial triage, assessment and tariff setting, before allocating service users to either a prime recovery provider or provider framework (DH, 2010).

### 4.2.1 Activity

A number of foundations needed to be in place to facilitate the delivery of the SPA within the pilot site.

#### Appropriate premises

The SPA was set up in a designated premise in the community. This facilitated greater access for service users, and was also seen by staff and stakeholders as key to encouraging recovery in the community and recovery networks, both of which were highlighted in the 2010 Drug Strategy as crucial to recovery (HM Government, 2010). The location of the SPA was also seen as important to facilitate self-referrals.

“It was picking a building that was in a well known area, in a high street location, that our service users would be able to access. And the idea behind it as well is that, it’s an open-access service, so partner agencies can refer people in, but service users can also drop in without an appointment and see somebody, there and then.”

(Stakeholder, Site 3, Stage 2 interview)

### Independent staffing and workforce development

SPA staff were employed through the Local Authority’s Health and Social Care Directorate and the DAT, not through one of the existing drug service providers. Having the SPA staff as independent from the local drug service providers was seen by stakeholders as central to their ability to refer service users to the most appropriate services rather than their own, as they did not have any allegiances or referral targets. Service users were therefore given a real choice in which services as described by this stakeholder.

“I think it gives the service user a genuine choice. And it means that whatever their need is they should be referred into the most appropriate service... Not the most convenient service.”

(Stakeholder, Site 3, Stage 3 interview)

Another activity undertaken to facilitate the SPA was a programme of workforce development which included joint inductions for all drug treatment staff working in the pilot area along with role shadowing and other training.

### Partnership working

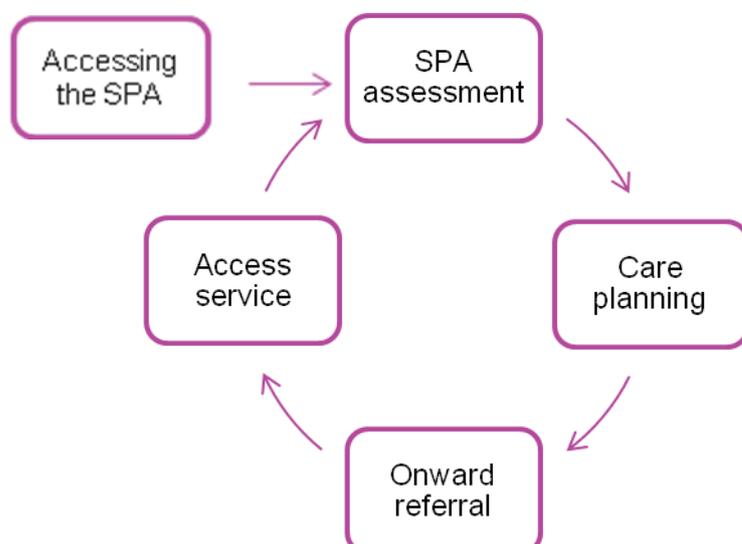
Partnership meetings were set up where all of the local drug service providers including the SPA manager met and any issues within the treatment system could be addressed.

As with the set up of SDS no freedoms and flexibilities were required to set up the SPA; no changes were made to the delivery of services within the treatment system or the commissioning of services.

## 4.2.2 Service user journey

The following diagram represents how the SPA works within the pilot area. This section then goes on to explore the different elements of the service user journey.

Figure 4.2 SPA service user journey



## Accessing the SPA

The introduction of the SPA changed the way that service users accessed treatment. New service users were assessed through the SPA before being referred onto treatment rather than accessing treatment services directly with no independent assessment. There were two main routes into the SPA either through referral from another agency or self referral.

### Referral

Service users could be referred to the SPA from a number of sources such as GPs, community mental health teams, community drugs teams and other substance misuse services. The SPA staff reported an increased number of referrals from GPs and community mental health teams after the SPA had been implemented; this was thought to be because they felt more comfortable referring into SPA as part of the health and social care system rather than drug treatment system. The SPA was also actively promoted within the local area, ensuring that local partners were aware of the services on offer.

### Self referral

The SPA building was based in the community meaning service users had direct access and were able to self refer. There was also a “*no wrong door*” policy whereby anyone in the community could be assessed at the SPA for onward referral. Increased self referral was attributed to there being less stigma attached to the SPA than to other drug treatment centres. The presence of service user mentors within the SPA (discussed further in Chapter 5) also meant that potential service users could see the positive engagement of the mentors, which fostered the view that recovery was possible. One service user mentor explained how they had encouraged other people in recovery to access the SPA.

“I’ve actually advised people to come here when they are still off it. I said you get seen by guys that have been through it, wore the T-shirt, you can relate to them more.”

(Service user mentor, Site 3, Stage 3 interview)

There were also changes to the profile of those being assessed. Staff from stage three of the research reported that the profile of drug use had changed from primarily opiate users to include cannabis, stimulant, benzodiazepine, crack cocaine and polydrug users. Staff also reported that more young women and 18 to 25 year old male cannabis users were accessing the SPA. This could be due to the changes in referral routes and an increase in self referrals for these groups.

“This [the SPA] has enabled people who have got substance misuse issues to actually access services. I think it’s opened the door for people. Those people that historically wouldn’t seek us out for assessment.”

(Delivery staff, Site 3, Stage 3 interview)

Despite improvements made to accessing drug treatment services through the SPA, there was a concern amongst delivery staff that the SPA was actually delaying access. Two reasons were identified for such delays. The first was that all services users need to be referred to treatment via the SPA, and so even those who presented directly to a service would be referred back to the SPA for an initial assessment. Limited staff capacity to undertake assessments at the SPA also resulted in delays for service users and subsequent onward referral to treatment. At stage three of the research some of these delays had been addressed by an increase in assessment staff, with the service

aiming to carry out assessments within five days of referral. SPA administrative staff were also undertaking service user triage, identifying service users in need of priority appointments such as those with mental health issues, pregnant women and cases involving child protection issues. Delivery staff were concerned about potential delays in accessing treatment, as they felt they could result in service users disengaging from drug treatment altogether.

“We can’t take direct referrals from hostels... They’re getting bounced back to the single point of assessment and having to wait and they’re losing interest by that point because you’ve got to strike while the iron is hot in a programme like ours.”

(Delivery staff, Site 3, Stage 2 focus group)

There was an additional concern that service users referred via the CJS would be at risk of breach due to such delays.

However, delivery staff were not always concerned about delays in accessing treatment as it was felt these were balanced by the SPA referring service users into *appropriate* services, more quickly. For example, it was felt that access to detoxification and rehabilitation services was sped up through the SPA. However, staff did voice some caution here and highlighted the importance of referrals being appropriate, as an unsuccessful detoxification can lead to an increased risk of overdose.

## Assessment

The SPA assessments were completed by five dedicated assessment staff based in the SPA; four of whom were employed through the Health and Social Care Directorate and the fifth through the DAT. The fifth assessor was employed in the later stages of the pilot to deal with increased demand for assessments and to ensure that the SPA could operate at full capacity when the manager was attending meetings. The success of the assessment rested upon the assessment tool itself as well as the staff undertaking it.

### Assessment tool

The comprehensive assessment covered health and social care needs in addition to substance misuse needs and had been approved by the Health and Social Care Directorate. While this assessment was valuable in giving a complete picture of the service user’s need, one stakeholder raised concerns that it was too long in its current form and collected information which was not required to make treatment referrals.

### Experienced staff

Having previously worked within drugs teams, the SPA staff had experience of working with this service user group and knowledge of services available in the area. These skills were seen by stakeholders as invaluable for completing the comprehensive assessment. SPA staff had also undergone additional training through the Health and Social Care Directorate to equip them with knowledge of the mainstream services available in the area and how they could be of benefit to service users.

## Care planning and onward referral

After the assessment, SPA staff would then complete a care plan with the service user. This included all services which they would access as part of their treatment, including services aimed at addressing their substance misuse as well as services such as housing, ETE, benefits and specialist counselling. There were a number of factors that impacted on the nature and extent of referrals into treatment services, as follows.

### **Increased workforce understanding**

Workforce development and shadowing opportunities equipped assessment staff with a greater awareness of what services were available within the local area. As a result, they were able to provide service users with more detail about what to expect from a particular service. One service user reported feeling anxious about being referred to the local prescribing service and only being offered methadone. The SPA staff member was able to offer additional information on the service, explaining that other medications such as buprenorphine (Subutex) were available there. The service user felt that without this support from the SPA and the confidence it had instilled they would not have attended their first appointment at the prescribing service.

“This place [the SPA] put me straight before I went in, I’d rather come here first and get prepared for it... But these [the SPA staff] explained what it [Subutex] does and they’ve got it spot on. I don’t think the doctors might have told me that so I’d have just plumped for Meth[adone].”

(Service user, Site 3, Stage 3 interview)

### **Independence of assessment staff**

The independence of the SPA assessment staff meant that they were not allied to any single provider. Therefore they referred service users to the most appropriate drug treatment and mainstream services, and not only services offered by their provider agency. One member of staff reported that this was key to the success of the SPA; the previous approach of his provider had been to retain service users in their own service, rather than offering a choice.

“When I used to do assessments at the [name of treatment provider] it was “This is what you get, you’re staying here”, and then you’re parked up here and that’s what happened. But [now] there’s a lot more choices.”

(Delivery staff, Site 3, Stage 2 focus group)

### **Co-location of other services**

Staff providing housing and welfare advice were also located within the SPA. The intention of co-locating these staff was to provide greater wrap-around support and encourage the referral of service users into these services.

### **Diversification of services**

Along with making more appropriate treatment referrals staff also spoke about greater provision for service users who were not opiate dependent, in particular cannabis and stimulant users who could now access a structured day programme.

### **Information sharing**

There was no shared IT system for making referrals to other services or transferring service user information from the comprehensive assessment. Paper assessment and referrals forms were scanned and sent via secure email. This was an improvement from stage two of the research where this has been done by fax. Although there were no immediate plans to set up a joint IT or case management system for treatment providers, staff spoke about how this would be desirable to facilitate information sharing and continuity of care.

Upon referring service users to the appropriate services the responsibility for ongoing case management was taken over by the relevant service provider. Although case management responsibilities were not held within the SPA, the weekly partnership meeting was used to discuss all referrals and to ensure that service users who had not attended their appointments were followed up. Referral and treatment commencement data was also monitored. Within the pilot site there was discussion of incorporating a case management function to facilitate greater continuity of care through the treatment

system. However, additional staff would be required to perform assertive outreach to re-engage service users if they dropped out of treatment, and as such this development was not seen to be feasible during the pilot.

## Referral back into SPA

Contact with the SPA was not limited to one assessment; service users could be re-referred or refer themselves back to the SPA at any point during their treatment or on completion. For example, one service user referred themselves back to the SPA to access post-traumatic stress disorder (PTSD) counselling. Similarly any one of the providers could refer a service user back to the SPA after completing a course of treatment.

### 4.2.3 Impacts

The services available in the area did not change as a result of the SPA. What did alter was how service users accessed services and which services they took up. This was facilitated by the independent nature of the SPA and assessment staff working within it as already discussed. Two key impacts of the SPA were increased partnership working and improved access to appropriate services.

#### **Increased partnership working**

The SPA operated within a partnership approach as described in Chapter 2. Providers within the pilot site no longer saw themselves competing for service users but instead took joint responsibility for their treatment within the system. This was recognised by service users who saw staff attending other services to increase their own knowledge.

*“They all interact with each other. There’s a lad here today who works in [provider] and he’s come down here for the day just to see how this [other provider] works. I think [name of staff member] has been down here from [provider]... They do all interact and slot in with each other. They all know each other.”*

*(Service user, Site 3, Stage 3 interview)*

#### **Improved access to appropriate services**

The independent nature of the SPA was felt to have facilitated greater access to appropriate services for service users.

*“I think it’s good, it’s just one place... and it puts you onto whatever you want to do, if it’s getting on a script, needle exchanges, getting into rehab / detox, it’s all available from here...I think it’s a really good idea.”*

*(Service user, Site 3, Stage 2 interview)*

Specifically, access to ETE was felt to have increased due to the SPA, either through referrals from assessment staff or through the co-location of representatives from ETE services in the SPA building. Increased confidence in the SPA assessment was felt by staff to mean that service users talked more openly during their assessment which led to staff having a greater understanding of the issues they faced.

The quantitative analysis shows that the pilot site delivering the SPA significantly increased the proportion of service users in effective treatment compared to that achieved by the comparison site during the pilot period. Further exploration of the impact of the pilot on effective treatment is provided in Chapter 6. In terms of the impact of the pilot on successful completions, the direction of change was positive with more service users successfully completing treatment during the pilot period (although this change was not statistically significant) so no firm conclusions can be drawn.

#### 4.2.4 Wider roll out

With regard to wider roll out and future operation of the SPA, the only changes to the SPA highlighted by staff interviewed for stage three of the evaluation was investigating how criminal justice service users could be brought into the service and how to integrate case management into the SPA. While not unfeasible, both developments would require additional staff resources to be brought into the SPA. This would require the funding allocations and contracts for all providers operating in the area to be amended which was beyond the scope of the DSCP.

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## 5 Delivery Changes

Pilot status enabled pilot areas to affect change to their treatment structures and systems through commissioning, partnership working, continuity of care and personalisation, as described in Chapters 2, 3 and 4. In turn, these structural changes presented pilot sites with the opportunity to re-model their treatment delivery to support and complement these new systems. In particular, pilot areas took the opportunity to re-orient their treatment provision towards a greater focus on recovery and reintegration. This chapter explores the range of approaches pilots took to achieving this: service user mentors; ITEP/BTEI node-link mapping; family therapy/group conferencing; ETE; housing and mutual aid.

### 5.1 Service user mentors

As a primary goal of system change was to promote recovery and re-integration, several pilot areas developed service user mentoring provision which was felt to support this in two ways. Firstly, by encouraging current service users to engage with treatment by providing peer support and role models for recovery, and secondly, to support service users in their own recovery journeys by providing opportunities to take on mentoring roles that built confidence, improved self-esteem, and offered a stepping stone towards paid employment. The roles taken by service user mentors across areas included co-facilitation of treatment groups, one to one support, prison gate pick-ups, attendance at appointments and advice and guidance on treatment options. The following two case studies illustrate the ways in which pilots sought to incorporate service user mentoring into their wider treatment systems:

#### **Case study 1**

A primary goal of this pilot area was to improve access to and engagement with treatment. To facilitate this, service users who were already engaging successfully with treatment were approached to become treatment mentors. These mentors were co-located with staff who were assessing service user treatment needs in a SPA. Their role was to provide advice and guidance on the range of treatment options available from the perspective of someone who had been a service user themselves. The rationale for this was to ensure service users were able to make informed decisions about the options available to them and in doing so increase the likelihood of retention in treatment and successful outcomes.

*“A lot of people, as they show [up to] rehabilitation centres, detox units, they don’t actually know what they’re signing up for... They’re just going in blind... The [mentors] can give an insight and speak to people [and say] ‘This is what you’re signing up for’... At least if you know what you’re going in for, you know what to expect, I think you’ve got a lot more chance of succeeding.”*

*(Delivery staff, Site 3, Stage two interview)*

Alongside this primary aim, treatment mentors were also thought to be the cornerstone of building a strong recovery community in the area by simultaneously providing role models for service users yet to engage with treatment, and by providing service users who were exiting treatment a positive experience of mentoring as part of their own recovery pathway. In being independent of treatment providers, mentors felt

able to focus on the individual needs of service users and support them to access a range of services from across the treatment system.

### **Case study 2**

A priority for this pilot area was improving continuity of care and maintaining engagement in treatment on release from custody. To support this aim, a service user mentoring service that had already been successfully developed in the community was extended into the prison setting. The aim here was to build support within the prison but also to offer service users the opportunity to continue with their mentoring role in the community, and thereby support their retention and engagement in treatment upon release. The mentoring role involved participating and co-facilitating treatment groups in prison and on release. A service user who experienced the mentoring role in both locations was very positive about the motivation and purpose the role gave him.

“I’m glad things are going the way they are, because it’s a better life... When I was on drugs it was a boring life, and I’ve got a bit more excitement in my life, something to do everyday... I can come to [name of treatment service] any day I want. Now I’m a peer mentor it’s my role to take part in things. So I’d rather do that than go and score.”

(Service user, Site 4, Stage 2 interview)

Developing the service both in prison and community CJS services was seen as facilitating continuity, but the challenges of working in a prison environment were also identified. In particular, staff were concerned that peer mentoring in prison could place high demands on prisoners who would be living with their peers full time. There were also limitations in terms of how much work could be done with prisoners on remand because of uncertainty over the length of time they would be in custody.

## **5.1.1 Impacts**

Previous research into the impact of peer mentoring schemes on outcomes across a range of different settings have identified positive impacts including improved mental health and interpersonal relationships, whilst acknowledging that further research is needed (Finnegan et al, 2010). The small size of the peer mentoring schemes piloted under the DSCPs makes it difficult to assess their impact quantitatively. However, the qualitative interviews found that impacts from peer mentoring were identified for both mentors themselves and the services users accessing them. For peer mentors, the role was felt to increase confidence and self-esteem and consequently play a critical part in their own recovery.

“I’ve always been frightened to make the final step... I’ve been like on medication for quite a long time... It’s only now that I’ve been given the confidence and... the drive to go for that now... 12 months ago... I’d got so far but I wasn’t able to make the final step... and this has helped me [with] the encouragement and the confidence to make the final step.”

(Peer mentor, Site 3, Stage 3 focus group)

The role was also viewed as a stepping stone into employment, by providing work experience and building confidence.

“I’ve been in the system for 20-odd years... It’s only over the last 12 months or so that I feel like there’s someone giving me a little push... and [giving] me the opportunities because I know, for a fact, that this is the only way that I had an opportunity of [getting experience in] a professional role... and that’s always been the reason why I haven’t been able to get a job in the past.”

(Peer mentor, Site 3, Stage 3 focus group)

For service users accessing treatment, the peer mentor role was valued because they were felt to understand the service user perspective because of their own past experience. This shared experience was felt to engender trust and service users spoke about finding it easier to open up to peer mentors because of this. They were also viewed as positive role models who were successfully tackling their substance misuse and contributing to the development of recovery communities in the pilot areas where they were embedded.

In developing peer mentoring schemes of this kind, pilots identified a range of facilitators that underpinned effective provision.

### **Training and development**

Comprehensive training is crucial to ensuring the ethical, effective, and consistent delivery of any service (McNaughton Nicholls et al., 2010). As such, good quality training was viewed as critical to successful peer mentoring programmes. Training with service providers was particularly valued as it facilitated joint-working and co-operation. Accreditation of peer mentoring programmes was also felt to be key to engendering staff and service user confidence in the service.

In addition to training for the mentor role, scope for development in the role was also seen as important – an acknowledgement that taking on the mentor role plays an important part in the mentor's own recovery. One pilot had developed a phased approach with mentors starting as trainees, progressing to senior mentors and ultimately accessing opportunities to take on wider roles within the treatment system. In another area, peer mentors had successfully moved into paid positions with treatment providers. Such progression was highly valued by mentors.

### **Supervision and ongoing support**

Regular supervision for peer mentors was felt to underpin good practice and support mentors to deliver an effective service. Ensuring they could take the role at their own pace was important to mentors and regular supervision ensured that mentors were given the right support to enable them to carry out their roles effectively. The role of supervision and ongoing support in peer mentoring schemes is supported by previous research into peer mentoring effectiveness (Finnegan et al, 2010).

### **Risk management**

Ensuring the safety of both mentors and service users was paramount to pilots delivering these services. Clear risk management protocols were embedded to ensure the safety and success of provision in the long-term.

### **Communication**

Clear communication on the role of mentors to service users and delivery staff was felt to be crucial. Post-pilot, areas were exploring co-location of mentors and treatment staff to facilitate good working relationships. Joint team meetings between service providers and mentors were also felt to cement joint-working and co-operation.

### **Stakeholder engagement**

The motivating and momentum-building role of senior staff when a new service or policy is being implemented is well documented (Turley and Webster, 2011; McNaughton Nicholls et al., 2010). In the pilot sites, senior stakeholders committed to the peer mentoring approach and willing to champion the service both in terms of funding and staff time was viewed as crucial to success.

## 5.2 ITEP/BTEI assessment and care planning

To improve the quality of assessment and care planning, a number of pilot areas rolled out training on International Treatment Effectiveness Programme (ITEP) or Birmingham Treatment Effectiveness Initiative (BTEI) mapping methods and introduced these into their existing assessment and care planning tools. These programmes utilise node-link mapping techniques for care planning and previous evaluations have found positive outcomes from their use, including improved service user engagement with treatment (Campbell et al., 2007). In one pilot, these methods were used as a foundation for re-designing the assessment and referral paperwork across the criminal justice treatment pathway, with the intention that they would replace existing paperwork and support continuity. Node-link mapping of this kind has been increasingly used in substance misuse services, and in 2010 the NTA developed a user guide for the use of mapping techniques in prison drug treatment services (NTA, 2010), with prison CARAT staff using node-link mapping in their assessments since April 2011 (Home Office, 2011).

### 5.2.1 Impacts

Delivery staff spoke positively about the use of these mapping techniques, describing them as more interactive and service user-led, which in turn improved service user engagement with the care planning process and ensured that the support offered to service users was more personalised. Mapping techniques of this kind were also valued by staff and service users as a tool to review progress.

*“We had a piece of A4 and we had a wiggly line and... at each stage on the wiggly line there's a goal. That's a goal, that's a goal, that's a goal... It was like a graph chart of where I wanted to go... It's nice when you reach one of them goals. You know when you are going forward, even though [I've felt] so many times in... the last 12 months, that things are stagnating and aren't getting any further... but if I looked back on where I was, you can always look back and [think], no, I've done this, I've done that... I'm halfway there.”*

*(Service user, Site 7, Stage 3 interview)*

In addition to ITEP/BTEI methods, pilots also used complementary evaluation tools designed to improve organisational self-evaluation and monitoring. As discussed in Chapter 2, some areas utilised the ORC and the CEST tools, and those that did spoke positively of their impact. In particular, the roll out of CEST was thought to be a significant improvement in monitoring service user progress and improving the quality of interventions, and ORC assessments were felt to be valuable in supporting treatment providers to critically evaluate their own practice and take responsibility for the quality of the services they were providing.

## 5.3 Family therapy/group conferencing

In seeking to improve outcomes for service users it was widely acknowledged that treatment systems needed to address the needs of service users in a holistic way. As part of this agenda, a number of areas took the opportunity of pilot status to explore forms of family therapy or family group conferencing. The aim of introducing such support was to address the needs of the whole family and in doing so, support the service user in their recovery journey by improving family relationships, building support networks, and addressing issues that may have contributed to their substance misuse.

A particular focus within the pilots was providing this form of support within a prison setting, and some progress was made towards this with two pilot areas delivering some form of family therapy/conferencing within a prison environment. Challenges to implementation included addressing security concerns and providing a suitable

environment, but ultimately these barriers were felt to be surmountable if there was commitment from prison service staff to facilitate and support delivery.

Two distinct delivery models were piloted under DSCP.

### **Single episode family group conferencing**

This approach involved a single family group conference facilitated by an experienced practitioner from the pilot area's Children's Social Care Team. The emphasis was on facilitating families to explore and address their problems in a way that would be self-sustaining, with a review held six months post-intervention. The target group was service users with substance misuse related offending with a child in the family.

### **Systemic family therapy over multiple sessions**

This approach involved working with families over a number of sessions using a systemic family therapy approach with the aim of improving family relationships and communication as well as improving substance misuse related outcomes for the service user. The target group was service users with a substance misuse problem who were in contact with the CJS. An existing specialist service that was already providing a similar service to another target group in the pilot area was funded for a year during the pilot to deliver the service.

## **5.3.1 Impact**

These pilots were small in scale (in one case funding was for six interventions in total), so it is not possible to explore their impacts quantitatively. However, staff working in this area felt support of this kind had improved family relationships and communication and as a result increased motivation for service users to address their substance misuse. Service users were similarly positive.

*"We just sat and we talked honestly... So, it was really good because we've never actually all spoken as a family. They might talk amongst themselves and they might talk to a couple of my sisters, but we don't all talk about it... It's been a big weight off... There's a lot of guilt... and a lot of shame... it's been hard, but there aren't no resentments... It is what it is and we've got to move forward, and we all said that."*

*(Service user, Site 7, Stage 2 interview)*

In terms of the wider treatment system, family therapy/group conferencing was felt to be a positive attempt to look wider than the individual service user and work with the whole family, in recognition of the importance of family support in recovery.

By stage three the site piloting systemic family therapy was not planning to continue the service post-pilot because the intensive nature of it was costly and the site did not have the resources to continue to fund it and roll it out across the area. The pilot area that had trialed the single episode approach was entering into a service level agreement with the Children's Social Care team to continue this provision post-pilot. This development was viewed positively by both services as an example of new partnership arrangements developing from the DSCPs.

## **5.4 Education, Training and Employment**

Access to ETE is widely regarded as an essential element of recovery, and this was reflected in the 2010 Drug Strategy's commitment to helping people find sustained employment (Home Office, 2010). Service users stressed the need to keep occupied and highlighted how employment could build their confidence and support them in moving

away from a lifestyle built around substance misuse. At the same time as acknowledging these benefits, service users also highlighted a number of barriers to accessing ETE including the stigma attached to having had a substance misuse problem, the lack of confidence associated with being out of the job market for a long period, and in some cases the difficulty of finding employment when they had a criminal record. Other commonly acknowledged barriers to accessing ETE were raised, including lack of childcare and concerns that low paid employment would mean they were worse off than when claiming benefits.

It was within this context that pilot areas introduced initiatives to incorporate ETE provision into pilot delivery. The range of initiatives introduced included building relationships with Welfare to Work providers; working with employers to dispel common misconceptions about substance misuse; providing ETE mentors; mapping existing ETE provision to make better use of existing services; training staff to increase their awareness of ETE services and using SDS to enable service users to identify and address their own training needs.

A key aim across all pilot areas was to ensure that existing ETE provision already funded to work with vulnerable groups, including those with substance misuse problems, was harnessed and utilised effectively. Building effective partnerships with JobCentre Plus (JCP) and Welfare to Work programmes and streamlining commissioning to make better use of existing resources were some of the ways pilots sought to achieve this. The following case examples illustrate pilot activity in relation to ETE provision.

#### ***Case study 1: Outreach JCP advisor & ETE working group***

This pilot area worked in partnership with JCP who were represented on their pilot board. A JCP representative chaired a working group of partner agencies set up with the intention of tackling issues related to the ETE needs of drug treatment service users and promoting better coordination of ETE provision across the treatment system. Outputs from the working group included the development of a directory of ETE provision to promote awareness of the services available in the area, and delivery of a series of seminars to service providers to raise their awareness of the ETE support available. A directory of employers who were willing to work with ex-offenders was also compiled to support substance misusing offenders who faced additional barriers to finding work.

The JCP also worked with the pilot area to fund an outreach worker who rotated across three of the main treatment providers one day a week, to facilitate service user access to support and advice in an environment they were already familiar with. Post-pilot the intention was to continue with this outreach provision to facilitate partnership working between the JCP and treatment providers.

#### ***Case study 2: ETE and continuity of care on release from prison***

This pilot area sought to improve continuity of care for drug misusing offenders released from prison by exploring ways to improve access to benefits. Delays accessing Jobseekers Allowance (JSA) or Employment Support Allowance (ESA) on release were felt to put additional strain on substance misusing offenders, increasing risk of relapse. The pilot worked with the Department for Work and Pensions (DWP) and local JCPs to find possible solutions to this. An initial freedom and flexibility request to allow offenders in custody to apply for benefits pre-release to avoid payment delays was turned down because it would require changes in statutory legislation. As an alternative, a small pilot was trialed in one area where offenders released from custody were referred to a named JCP advisor who specialised in

supporting service users in these circumstances. Work was also done with staff releasing substance misusing offenders from custody to raise their awareness of eligibility criteria for the ESA and to explore alternative forms of personal identification as a lack of appropriate ID (e.g. passports, birth certificates) was identified as a barrier that delayed benefit claims. This information was then disseminated to partner agencies including probation and treatment providers so that they could support their service users in accessing support.

### 5.4.1 Impact

From service user interviews it was clear that access to ETE opportunities could have a very positive impact. In one case for example, a young man had been supported by a JCP advisor linked to his treatment provider to apply for an apprenticeship, and he felt positive and motivated about the future as a result. In another case, SDS had enabled a service user to access training that built his confidence.

*“I learnt so much, yeah it was brilliant... and I feel very grateful that I’ve done it... Very good for my self-esteem, my confidence and made me feel like I was worth something, and... that I could do it.”*  
(Service user, Site 1, Stage 2 interview)

Staff found it challenging to unpick the impact of ETE pilot activity on service users, because the pilots coincided with a challenging economic climate and monitoring data on employment was not always felt to be reliable. Some staff also held the view that other areas of support, particularly in relation to housing, should be prioritised over ETE as a more pressing need, arguing that service users could not engage with ETE services until other key needs including housing had been met. At a strategic level, uncertainty in terms of budget cuts both locally and nationally (both during and post-pilot) were identified as barriers to moving forward in this area, particularly in cases where partnership arrangements had been established between JCP and local treatment services, as there was concern that budget retrenchment would reduce capacity for this form of working.

## 5.5 Housing

Stable housing was identified by service users as crucial to their recovery, and it was not uncommon for housing crisis to be identified as a trigger for relapse. It was in this context that pilots were striving to tackle housing needs. At a delivery level measures piloted included training case managers to provide housing advice, co-locating local authority housing staff within a SPA to improve access to advice and support, employing a dedicated housing officer to work with service users, putting in place measures to provide emergency bed and breakfast accommodation for those released from custody, and supporting service users to access mainstream services by providing advocacy. One pilot had also accessed a freedom and flexibility to enable the local authority to provide the option of managing Community Care Grants on behalf of service users, by holding the funds in bank accounts on their behalf.

### 5.5.1 Impact

Examples of positive impacts of housing support included one service user who received help to address rent arrears that were preventing him from accessing housing. In another case, a service user received help with finding accommodation on his release from custody, which he identified as a major factor in his recovery, particularly because it was away from the environment in which he misused drugs.

“Accommodation, that’s the most important thing, if you ain’t got a roof over your head then I’d just go back to [previous area], back to the people I know... It’s given me a good boost, it gives you security, [and] peace of mind as well.”

(Service user, Site 2, Stage 2 interview)

Alongside these positive impacts however, some service users continued to identify housing concerns as a risk to their recovery and staff also identified housing need as an area that needed further attention. Pilots reported varying success in working with housing support services to meet the needs of service users. In one area for example, a re-tendering process for housing support services was put on hold as a result of budget retrenchment, preventing the pilot from using the re-tendering process to build in specific provision for service users. However, another area was successful in working with local councils to have service users in (or exiting from) treatment defined as ‘vulnerable’ for the purposes of local housing allowance, providing them with more housing options.

## 5.6 Mutual aid

In reconfiguring treatment systems, some pilots were seeking to develop mutual aid groups in their area including Narcotics Anonymous (NA) and Cocaine Anonymous (CA). The aim of this was to support the creation of an active recovery community in the area.

“We never had that culture [of] people visibly in recovery being seen with other clients, and we obviously know that can have a massive impact on somebody’s treatment if you can actually see somebody who’s done well and come back and reintegrated back into their own area.”

(Stakeholder, Site 3, Stage 2 interview)

Methods adopted to help develop independent mutual aid groups included supporting service users to set up their own groups by providing premises in which discussions could be held, providing budgets for room hire, and providing refreshments. As work progressed, pilot areas spoke of the importance of ensuring treatment staff had a good understanding of the range of different mutual aid groups available and were equipped with the knowledge to refer service users appropriately. One suggestion for achieving this in the future was to encourage treatment staff themselves to attend some mutual aid groups to build their knowledge of provision. Peer mentors also played a key role in raising awareness and linking service users into this kind of provision with positive results.

“I met another mentor, he was in NA... and he just asked me to come along to a NA meeting one night, and I went and it just blew me away and I thought this is what I’ve been looking for so many years.”

(Service user, Site 4, Stage 3 interview)

### 5.6.1 Impact

Service users who participated in the research stressed the importance of having a range of provision available to support recovery. For some, mutual aid was viewed very positively and regarded as a key element of their recovery, while others preferred alternative approaches. For those who found such groups beneficial the increase in mutual aid in some pilot areas as a result of pilot activity was viewed positively because it meant they were increasingly able to sustain recovery locally, where previously they had felt that they had to move from the area if they wanted to achieve successful treatment outcomes. One service user for example, was attending groups of this kind every day and was also planning to set up his own group.

In relation to fostering mutual aid provision in the long-term, one issue raised by stakeholders was that this kind of support was not reported on the NDTMS. Consequently any increased use of mutual aid provision as an alternative to Tier 3 services would impact negatively on targets that focused on referring into Tier 3 provision. While this did not prevent pilots actively seeking to support this kind of provision because of the benefits it could bring to service users, some stakeholders thought that targets and the way in which activities were recorded on NDTMS needed to be revisited to avoid disincentives to providing support of this kind.

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## 6 Impacts: Effective treatment and successful completions

The DSCP programme was concerned with the whole system for delivering drug treatment rather than with the substantive content of treatment. It is important therefore to document the impact of the programme on treatment delivery as well as on treatment outcomes. While the latter will be the ultimate source of substantive benefits, there are various indicators which can be used to illustrate impact well before the crime reduction, health improvement and other effects can be reliably demonstrated.

For example, it may be that the ratio of successful treatment completions to the number in treatment can be increased by raising the degree of continuity between the provision of drug treatment in prisons and engagement in community-based treatment on release. The conjecture here is that the period immediately following release is a high-risk time for service users who may fall back into a chaotic lifestyle if not engaged with treatment as a matter of urgency. Improved continuity of care might thus reduce the proportion leaving custody and subsequently re-presenting for treatment after a damaging break in engagement with treatment services. Chapter 3 has already explored the extent to which pilots were successful in improving continuity of care in this way.

The impact of the programme on final outcomes such as offending and health is to a large degree mediated through the scale of the effects on pilot outputs and activity. To explore the impact of the DSCP programme we focus on the proportions of service users in effective treatment and the proportion completing treatment successfully<sup>27</sup> (see Appendix B for further discussion of the selection of outcome indicators). The idea is that successful overhaul of the systems for managing the delivery of drug treatment can increase the proportion for whom treatment is effective and increase the proportion completing treatment successfully. This chapter explores the impacts of the DSCPs on these indicators. It draws on data from NDTMS and uses a difference in difference approach (see Appendix C4 for further detail).

Before these indicators of pilot impact are discussed in detail, it is important to acknowledge a number of caveats.

- **Pilot complexity**

The pilots were complex with multiple strands of activity running simultaneously. Therefore it is not possible to attribute changes in the proportion of service users in effective treatment or successfully completing treatment to an individual project component. Instead, pilot activity must be viewed as a whole. In interpreting the impacts discussed here, refer to Table 1.3 in Chapter 1 for a summary of the key pilot activity in each pilot area.

- **Timescales**

Reconfiguring the system through which drug treatment is delivered at local level is a complex undertaking, the effects of which may take a considerable length of time to emerge. For example, changing the system for commissioning the delivery of

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<sup>27</sup> A client was in 'effective treatment' if their reason for exit indicated that treatment had been completed or their journey length was greater than or equal to 83 days. A client was deemed to have had a 'successful completion' if their journey ended within the period of interest and the journey exit reason indicated that treatment had been completed.

drug services will only usually be possible when contracts are due for renewal and will require a significant amount of forward planning since the procurement process may need to be changed. Likewise a move to introduce greater personalisation of treatment packages will take a considerable time to implement given the requirements for staff training, changes to information systems and so on. As discussed in Chapter 1, to account for delays in the start of pilot activity, the results presented here exclude the first six months of the two year pilot period.

Tracking the impact of the changes implemented under DSCP also requires an appreciation of the timescales that might be needed for establishing evidence of a change in performance. The stock of service users in treatment does not turn over particularly quickly, since it takes many service users a significant time between entering treatment and completing it (whether successfully or otherwise). The timescales of this evaluation mean that the results presented here reflect changes in the proportion of service users in effective treatment, and successfully completing treatment up until the end of the two year pilot period. For the full impact of pilot activity to emerge, a longer term follow-up is required. Caution should therefore be taken when using the results here to judge pilot success. This is particularly true of the results for the proportion of service users successfully completing treatment, as treatment journeys are typically long and the impacts of pilot activity are not likely to be fully revealed until long after the end of the official pilot period.

- **Pilot focus**

Four of the seven pilot areas were ‘criminal justice’ pilots, meaning their focus was on improving drug treatment provision for service users within the criminal justice system exclusively. Two pilot areas were defined as ‘whole system’ pilots, reflecting their intention to affect change across the whole treatment system, while the final pilot trialled SDS on a small cohort of service users. These different foci have implications for how much weight can be placed on an analysis of effective treatment and successful completions.

In the case of the pilot area delivering SDS, the cohort affected was too small to explore quantitatively and so has been excluded from the analysis. The four ‘criminal justice’ sites were attempting to impact on a sub-sample of their broader treatment population, so it could be expected that their impact on numbers in effective treatment and levels of successful completions within the wider cohort might be lower. For the ‘whole system’ sites, it is fair to expect that their pilot activity would lead to improvements in these indicators as their pilot activities were aimed at all service users within their areas.

## 6.1 ‘Whole system’ pilot sites

The following table gives the results for percentages of service users (aged 18+) in effective treatment for the pilot areas adopting ‘whole system’ change.

**Table 6.1 Effective treatment in ‘whole system’ pilot areas \***

Area	2007-09		2009-11		Comparison		
	Total clients in treatment	% in Effective treatment	Total clients in treatment	% in Effective treatment	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value **
Pilot 3	1,914	93.6%	1,791	96.4%	+2.8%		
Comparison 3	2,462	94.7%	2,258	93.9%	-0.8%	+3.6%	<0.01
Pilot 7	3,869	95.3%	3,404	96.0%	+0.6%		
Comparison 7	3,421	97.4%	3,049	95.2%	-2.2%	+2.8%	0.04

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-0.1 percentage point when compared to the differences between the un-rounded figures shown.

\*\*After controlling for client characteristics.

This table shows that in both pilot areas adopting whole system change, the percentage of service users in effective treatment increased during the pilot period when compared to the pre-pilot period. In site 3 the percentage in effective treatment rose by 2.8 percentage points (ppts), while in site 7 it rose by 0.6 ppts. In both comparison areas the percentages decreased, thus, when compared to their comparison areas, the difference in difference was positive for both pilots at +3.6 and +2.8 ppts respectively.

Statistical modelling of this change, controlling for service user characteristics, showed both these improvements to be statistically significant (p<0.05). These results therefore suggest that both whole system pilots have helped to increase the proportion of their service users in effective treatment.

The results for these pilot areas in terms of the percentage of successful treatment completions are set out below. The percentages are based on the number of clients completing treatment, whether successfully or not.

**Table 6.2 Successful completions in ‘whole system’ pilot areas\***

Area	2007-09		2009-11		Comparison		
	Total clients completing treatment	% Successful completions	Total clients completing treatment	% Successful completions	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value **
Pilot 3	608	39.1%	780	62.1%	+22.9%		
Comparison 3	749	26.2%	956	41.3%	+15.1%	+7.8%	0.22
Pilot 7	949	34.9%	1,091	39.0%	+4.2%		
Comparison 7	674	27.2%	1,017	35.3%	+8.1%	-4.0%	0.15

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-0.1 percentage point when compared to the differences between the un-rounded figures shown.

\*\*After controlling for client characteristics.

These results show that in site 3 the percentage of service users completing treatment successfully during the pilot period rose to 62.1 per cent from 39.1 per cent pre-pilot, an increase of 22.9 ppts. The comparison area also showed an increase in the proportion of successful completions (+15.1 ppts) but the improvement was smaller, meaning the difference in difference was positive at +7.8 ppts. However, this change is not statistically

significant<sup>28</sup> partly because the relatively small sample size in this particular pilot area meant the statistical power to detect change was low. As a result, although the figures suggest a positive trend in successful completions, site 3 cannot be said to have had a measurable effect on the proportion of service users completing treatment successfully.

For site 7, the results show that the percentage of service users completing treatment successfully rose by 4.2 ppts (from 34.9 per cent pre-pilot to 39 per cent). However, this increase was higher in the comparison area (+8.1ppts), and so the difference in difference was negative at -4 ppts. However, this change is not statistically significant.

## 6.2 ‘Criminal Justice’ pilots

The following table gives the results for percentages of all service users (aged 18+) in effective treatment for the pilot areas focusing on their criminal justice treatment provision.

Area	2007-09		2009-11		Comparison		
	Total clients in treatment	% in Effective treatment	Total clients in treatment	% in Effective treatment	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value **
Pilot 2	3,322	90.8%	3,169	88.6%	-2.2%		
Comparison 2	2,425	91.9%	2,038	93.2%	+1.3%	-3.4%	0.01
Pilot 4	2,997	90.5%	3,166	92.7%	+2.3%		
Comparison 4	5,291	92.2%	5,390	94.2%	+2.0%	+0.3%	0.81
Pilot 5	2,726	94.7%	2,504	95.7%	+1.0%		
Comparison 5	2,392	87.8%	2,324	93.3%	+5.5%	-4.6%	0.02
Pilot 6	2,137	95.1%	1,841	92.7%	-2.5%		
Comparison 6	1,836	91.3%	1,769	95.4%	+4.1%	-6.5%	<0.01

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-0.1 percentage point when compared to the differences between the un-rounded figures shown.

\*\*After controlling for client characteristics.

Table 6.3 shows that in two of the criminal justice pilot areas, the percentage of service users in effective treatment declined during the pilot period when compared to the pre-pilot period. In site 2, the percentage in effective treatment fell by 2.2 ppts and in site 6 by 2.5 ppts. In the corresponding comparison areas, the percentages increased so the difference in differences were negative for both these sites (-3.4 and -6.5 ppts respectively).

In the other two areas, sites 4 and 5, the percentage of service users in effective treatment rose by 2.3 ppts and 1 ppt respectively. However, for site 5 the difference in difference was negative (-4.6 ppts) as the comparison site showed a greater improvement, while in site 4 virtually no difference in difference was found (+0.3 ppts).

In summary, in three of the four criminal justice pilot areas (sites 2, 5 and 6), the comparison areas made greater improvements in the proportion of service users in effective treatment than the pilot areas. Statistical modelling showed these changes to be statistically significant ( $p < 0.05$ ). This is perhaps unsurprising as pilot activity may be

<sup>28</sup> Using a statistical model controlling for client characteristics.

expected to cause some disruption at least in the short term. Longer term follow-up may be required to determine whether these trends persist.

In site 4 the difference in difference was close to zero (and not statistically significant) indicating there was no measurable difference between the changes in the pilot and comparison sites.

**Table 6.4 Successful completions in 'criminal justice system' pilot areas\***

Area	2007-09		2009-11		Comparison		
	Total clients completing treatment	% Successful completions	Total clients completing treatment	% Successful completions	Change ('09-'11)	Diff in diffs ('09-'11 and between sites)	p-value **
Pilot 2	1,657	55.2%	1,661	50.5%	-4.7%		
Comparison 2	608	34.2%	699	37.3%	+3.1%	-7.8%	0.10
Pilot 4	1,131	31.9%	1,233	39.0%	+7.1%		
Comparison 4	1,954	40.9%	2,309	44.2%	+3.3%	+3.8%	0.08
Pilot 5	1,015	41.3%	1,152	57.4%	+16.1%		
Comparison 5	1,018	34.2%	1,199	47.6%	+13.4%	+2.7%	0.30
Pilot 6	793	57.4%	878	43.6%	-13.8%		
Comparison 6	608	25.5%	789	31.9%	+6.4%	-20.2%	<0.01

\*All differences are calculated on un-rounded figures, therefore some may differ by +/-1 percentage point when compared to the differences between the un-rounded figures shown.

\*\*After controlling for client characteristics.

Table 6.4 shows that in two areas, the percentage of service users successfully completing treatment during the pilot period declined when compared with the pre-pilot period. In site 2 the figure fell by 4.7 ppts and in site 6 by 13.8 ppts. In the corresponding comparison areas, the percentages increased so the difference in differences were both negative at -7.8 and -20.2 ppts respectively. For site 6 this change is statistically significant ( $p < 0.01$ ), suggesting that pilot activity had a negative effect on the proportion of service users completing treatment successfully. In the case of pilot 2, the change is not statistically significant.

In sites 4 and 5, the percentage of service users successfully completing treatment when compared to the pre-pilot period rose by 7.1 ppts and 16.1 ppts respectively. The difference in differences against their comparison areas were also positive at +3.8 ppts and +2.7 ppts. However, neither change was statistically significant.

In interpreting these results, it is important to remember that these pilots focused their activity on their criminal justice treatment systems, with particular attention paid to continuity of care between prison and community treatment provision (discussed in Chapter 3). While the ultimate aim of enhancing continuity of care within the criminal justice treatment system was to improve outcomes for service users (including numbers in effective treatment and successful completions) it would be unfair to expect the impact on the overall proportion of service users in effective treatment, or on successful completions, to be as great as that in the 'whole system' pilot areas. It would be reasonable to expect a time lag before improvements to continuity of care translate to improved service user outcomes. Pilot activity was also disrupted in the short term as management structures, job roles and ways of working changed, particularly in areas that developed integrated criminal justice treatment systems. As a result, the full impacts

of DSC on these outcomes are only likely to become clear in the longer term. A re-examination of these indicators two to three years after the pilot would be valuable to explore further the full impacts of the DSCPs. Also of value would be an exploration of the proportion of service users who successfully completed treatment who then re-presented for treatment within the following twelve months. This would provide further evidence of the extent to which service users were able to maintain long-term recovery post-pilot.

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## 7 Benefits and costs

The purpose of this chapter is to explore the economic characteristics of the DSCPs and in particular the benefits it has delivered relative to the costs of its implementation. While previous chapters have explored the programme in terms of the types of change being implemented, this chapter has a site-level focus.

Each area implemented a distinctive blend of changes. Therefore associating the outcomes achieved (or the share of the budget required) by each individual component of change is not feasible. Each of the pilots is explored in terms of its objectives, costs and outcomes. However it is not possible to comment on the relative effectiveness of individual project components given the comparatively small number of pilots and their complex and heterogeneous composition.

The chapter begins with an analysis of project costs and then looks at the objectives and outcomes of each pilot. It concludes with an overall assessment of the DSCP programme.

### 7.1 Costs of DSCP

Each pilot received NTA funding for the two year period. The budget allocated to each site was agreed following initial submissions and depended on the scale of the pilot's ambitions and funding application. The budgets were primarily to meet some of the additional recurrent spending requirements of a project, although a significant sum was earmarked for capital spending in one area. The total earmarked for the projects was £2.986 m over the two years 2009-10 and 2010-11. The next section reviews the context of spending on DSCP.

#### 7.1.1 Funding of drug treatment

Combined funding from the Home Office and DH, known as the Pooled Treatment Budget (PTB), for commissioning drug treatment services is allocated annually to DATs. For 2010-11 the NTA was allocated £406m in central government funding for the PTB to distribute to local partnerships via PCTs, strategic health authorities (SHAs) and the Young People's Substance Misuse Partnership Grant. Allocations to DATs are made on a formula basis that recognises key deprivation factors. In addition to this central funding DATs also receive funding from local sources such as the police and PCTs, although the relative share represented by local funding has declined over the past decade from around 50 per cent of the total to less than 40 per cent: Appendix C7.

Total spending on the DSCPs amounted to £2.5 m over the two years of its lifetime (2009-10 and 2010-11). In 2010-11 this represented an addition of around 4% to the Adult Pooled Treatment Budgets (APTBs) for the pilot areas.

#### 7.1.2 DSCP implementation budgets

The pilots differed widely in the total amount budgeted and in the composition of their spending. In year one (2009-10) spending per pilot ranged from £52,268 to £269,014, and from £95,852 to £255,640 in year two. Table 7.1 summarises the composition of

spending by the main budget heads. Around two thirds of the spending went on pay and one third on non-pay items. Capital spending (on isolated or non-recurrent items such as building works) accounted for less than 10 per cent of the total budget, and was confined to the first of the two years.

	<b>All sites Actual</b>	<b>All sites Actual</b>		<b>All sites Actual</b>	<b>All sites Actual</b>
	<b>09-10</b>	<b>10-11</b>		<b>Both years, £</b>	<b>Both years, %</b>
Pay	£782,760	£760,248		<b>£1,543,008</b>	<b>62.7%</b>
Non-pay	£401,431	£313,213		<b>£714,644</b>	<b>29.0%</b>
Non-recurrent start-up	£203,418	£0		<b>£203,418</b>	<b>8.3%</b>
<b>Total</b>	<b>£1,387,609</b>	<b>£1,073,461</b>		<b>£2,461,070</b>	<b>100.0%</b>

In terms of the spending on pay, around half went on management, typically in the form of a project manager. Around 15 per cent went on administration and a slightly higher proportion on each of data analysis and specialist support. See Table 7.2 below.

	<b>All sites Actual</b>	<b>All sites Actual</b>
	<b>Both years</b>	<b>Both years</b>
		<b>%</b>
Management	£766,143	49.7%
Administration	£226,784	14.7%
Data analysis	£261,657	17.0%
Specialist support	£288,424	18.7%
<b>Total pay</b>	<b>£1,543,008</b>	<b>100.0%</b>

The two largest components of non-staff spending were for training (23 per cent) and consultancy (17 per cent). Travel/subsistence and conferences each accounted for about 8 per cent and rent for 6 per cent. See Table 7.3 below.

	All sites	All sites
	Actual	Actual
	Both years	Both years
Advertising	£18,950	2.7%
Training	£163,152	22.8%
Travel & subs	£56,319	7.9%
Hospitality	£13,825	1.9%
Conferences	£60,587	8.5%
Media	£16,000	2.2%
Consultancy	£118,623	16.6%
Incidentals	£66	0.0%
Rent	£45,000	6.3%
Overheads	£11,693	1.6%
Mentoring	£20,000	2.8%
Equipment	£641	0.1%
Internal recharge	£33,313	4.7%
Other exceptional	£156,475	21.9%
<b>Total non-pay current</b>	<b>£714,644</b>	<b>100.0%</b>

## 7.2 Output and activity

As discussed in Chapter 6, reconfiguring the system through which drug treatment is delivered at local level is likely to be a complex undertaking, and tracking the impact of the kinds of change implemented under DSCP requires an appreciation of the kinds of timescale that might be needed for establishing evidence of change in performance. In addition to these considerations, the stock of OCUs in treatment does not turn over particularly quickly and several episodes of treatment may be needed. Therefore the achievement of positive outcomes may require considerable patience.

In this section we review various indicators of output and activity in an effort to explore the impact of DSCP implementation. It is envisaged that improved efficiency will show up in the activity of DATs before it shows up in final outcomes such as reduced offending.

The model of the treatment system on which this analysis relies is the ‘stocks and flows’ model set out in Appendix C3.

### 7.2.1 Number of new treatment journeys

The assumption for this analysis is that an increase in the number of new treatment journeys represents a benefit since it means that a higher proportion of OCUs in an area will be in treatment. More efficient delivery of treatment should enable an increase in the capacity to take on new clients and thus a sustained increase in the number of new journeys started might be an indication of improved delivery.

By tracking the numbers of new journeys started in pilot and comparator areas it is possible to explore the possibility that the pilot areas are recruiting for new journeys at an enhanced rate. Figures C8.1–C8.6 in Appendix C (based on NDTMS data from

November 2011) illustrate the trajectories for the relevant pairs of areas over a three year window beginning in April 2008, 12 months before the start of the pilots in April 2009<sup>29</sup>. There is no clear evidence from figures C8.1–C8.6 that the number of new journeys started has increased more quickly in the pilot areas as compared with their comparators. In all cases there is a marked pattern evident within each fiscal year (April to March). Typically recruitment is most buoyant during the early and late stages of the year but flatter over the middle section, probably reflecting efforts to keep recruitment within a target range over the financial year. In most cases there is a downward trend, year on year, in the number of new journeys started. This is likely to be the result of downward pressure on funding, which constrains the total number in treatment and leaves less scope to take on new journeys. There are however some other possible indicators of delivery improvements, as discussed below.

## 7.2.2 Effectiveness of new treatment journeys

An increase in efficiency may result in an increase in the proportion of new journey starts that result in effective treatment, even if financial constraints are putting downward pressure on the number of new journeys started. Table 7.4 documents the proportion of the new journeys begun each fiscal year that resulted in effective treatment (because they lasted at least 12 weeks or because they were completed successfully within 12 weeks). The data for Table 7.4 are for four consecutive fiscal years, the first two (07-08 and 08-09) being the two prior to implementation of DSCP and the following two (09-10 and 10-11) covering the pilot period. This is different from the 18:6:18 month time intervals used for measuring outcomes because data on the effectiveness of new journeys are only published for complete financial years.

Site	Fiscal Year	Number starting new journey: Index, 07-08=100	% retained >12 weeks	% completed <12 weeks	% new journeys effective
<b>Site 1</b>					
	07-08	100.0	78.9	2.8	81.7%
	08-09	75.7	80.5	2.0	82.5%
	09-10	77.7	78.0	4.0	81.9%
	10-11	73.9	76.8	1.5	78.2%
<b>Site 2</b>					
	07-08	100.0	84.5	3.5	88.0%
	08-09	98.8	78.2	5.4	83.6%
	09-10	87.1	77.0	2.5	79.5%
	10-11	80.7	77.1	1.8	79.0%
<b>Site 3</b>					
	07-08	100.0	85.7	1.4	87.1%
	08-09	90.5	87.7	3.3	91.0%
	09-10	77.2	86.4	2.4	88.8%
	10-11	79.2	88.9	1.8	90.7%

<sup>29</sup> The analysis is based on data taken from the NDTMS website in November 2011. It is possible these data will have been revised subsequently.

<b>Site 4</b>					
	07-08	100.0	79.1	4.5	83.6%
	08-09	113.3	80.0	8.7	88.8%
	09-10	89.7	79.6	3.8	83.4%
	10-11	81.4	79.4	2.8	82.2%
<b>Site 5</b>					
	07-08	100.0	80.9	2.2	83.1%
	08-09	94.1	77.4	7.5	84.8%
	09-10	70.2	79.7	5.6	85.3%
	10-11	71.3	81.5	5.8	87.4%
<b>Site 6</b>					
	07-08	100.0	82.8	2.6	85.4%
	08-09	97.1	82.6	4.4	87.0%
	09-10	96.0	85.6	4.1	89.7%
	10-11	88.0	85.1	4.7	89.8%
<b>Site 7</b>					
	07-08	100.0	76.6	4.4	81.0%
	08-09	103.5	78.1	4.8	82.8%
	09-10	91.3	81.8	3.1	84.9%
	10-11	77.7	82.8	2.2	85.0%
<b>All sites</b>					
	years 1+2	100.0	80.8	4.0	84.8%
	years 3+4	83.8	81.2	3.0	84.2%

Taking the pilot areas as a whole, the volume of new journeys started fell from an index value for 100 for the two years prior to DSCP implementation to 83.8 during the two years of the programme's operation. The proportion of these journeys which was effective fell very slightly from 84.8% for years one and two to 84.2% for years three and four. The conclusion from this is that there is not any evidence that the effectiveness of new journeys started in the pilot areas improved significantly as a whole during the two years for which the pilot was running.

## 7.3 Managerial economies

Although the underlying objective is to achieve improved outcomes (as discussed in section 7.4 below), there is scope in some of the pilot projects to identify managerial savings resulting from the changes implemented as part of the pilot. Further investigation at one of the pilot sites revealed the scope for making savings as service delivery is reconfigured. The findings are not reported in detail but do represent a useful illustration of potential.

The principal sources of savings were: a reduction in the number of commissioning groups; fewer performance review meetings; fewer team meetings; fewer reporting requirements; fewer procurement processes; and rationalisation of drug assessments at court. Summing the estimated savings from these sources gives a total of £60,000 per annum as a minimum. Since this saving is expected to continue in perpetuity it could be expressed as a lump sum of considerable size, particularly given the low interest rates at

the time of writing. Alternatively the saving could be viewed as an opportunity to increase the stock of clients in treatment without needing to increase the treatment budget. There is likely, of course, to be a time lag between implementing the managerial reconfiguration and being able to take advantage of savings. It takes time to make adjustments to staff roles and responsibilities so it would be very unlikely that there would be much perceptible impact during the first year of the project.

## 7.4 Outcomes and impact

The central objective of drug treatment is to reduce the scale of harm resulting from drug abuse. The ultimate test of whether changes to the system for managing the provision of drug treatment have succeeded is therefore found in the impact on offending levels, health service use and the other sources of economic and social costs. As outlined in Chapter 1 it is possible to approach this either by looking directly at the offending and health service use of individual treatment clients going through DSCPs, or by looking at site-level data on the numbers in effective treatment and the number of successful treatment completions.

There are important limitations attached to the use of individual-level data, namely that the NTA's Treatment Outcome Profile (TO=P)<sup>30</sup> data refer to short time intervals and are based on self-reporting which may be unreliable. By contrast the use of site-level data on the extent to which treatment is effective and results in successful completion of treatment enables findings from earlier studies, such as DTORS (Davies et al., 2009) and the recent NTA study (NTA, 2011), of drug use careers and the associated costs to be exploited. An element of control is introduced into site-level analysis by using a difference in differences approach based on findings from comparison areas matched with pilot areas.

### 7.4.1 Effective treatment and successful completions

There are two points in treatment journeys which are critical from an outcomes perspective. The first is whether someone starting a treatment journey stays with it for some minimum length of time and becomes engaged with it. The second is whether, having completed the programme successfully, the client remains abstinent. At each of these two points in the timeline of a drug-using career there is the possibility that the individual will choose a pathway with lower economic and social costs. For purposes of discerning the impact of the DSCPs we focus on the proportions of clients selecting each pathway and explore how these proportions changed in the pilot and comparison areas. The conjecture is that successful overhaul of the systems for managing the delivery of drug treatment can increase the proportion for whom treatment is effective and increase the proportion completing treatment successfully.

Table 7.5 shows the pre- and pilot numbers in treatment in the pilot areas<sup>31</sup>. It also shows the proportion of the total engaging with effective treatment and the proportion completing treatment successfully<sup>32</sup>. The table indicates that there is variation in the proportion achieving effective engagement (ranging from 89% to 96%) and in the proportion successfully completing treatment (ranging from 9% to 28%) across the sites.

<sup>30</sup> TOP data includes self-reported information that is updated during the client's treatment journey including drug use, offending, housing need, ETE undertaken and physical and psychological health.

<sup>31</sup> Appendix B.2 provides a breakdown of how the pre- and pilot periods were defined for analysis purposes.

<sup>32</sup> Definitions of these terms can be found at: [www.ndtms.net/resources/Guidance/PDU-adult\\_report\\_guidance.pdf](http://www.ndtms.net/resources/Guidance/PDU-adult_report_guidance.pdf)

To infer benefits the test is whether engagement rates and/or completion rates increased in pilot areas relative to comparison areas.

Site	Stage	Total in Treatment	Effective Treatment	Successful Completions	E.T. as % of Total in Treatment	Succ. Comps. As % of Total in Treatment
2	Pre	3,322	3,015	915	90.8%	27.5%
	Pilot	3,169	2,808	839	88.6%	26.5%
3	Pre	1,914	1,791	238	93.6%	12.4%
	Pilot	1,791	1,726	484	96.4%	27.0%
4	Pre	2,997	2,711	361	90.5%	12.0%
	Pilot	3,166	2,936	481	92.7%	15.2%
5	Pre	2,726	2,582	419	94.7%	15.4%
	Pilot	2,504	2,396	661	95.7%	26.4%
6	Pre	2,137	2,033	455	95.1%	21.3%
	Pilot	1,841	1,706	383	92.7%	20.8%
7	Pre	3,869	3,689	331	95.6%	8.6%
	Pilot	3,404	3,267	426	96.0%	12.5%
<b>Total</b>	Pre	16,965	15,830	2,719	93.3%	16.0%
	Pilot	15,875	14,839	3,274	92.8%	20.6%

The total rows at the bottom of Table 7.5 indicate that across the six pilot areas analysed the proportion in effective treatment remained stable at around 93%. The number of successful completions increased, with the result that, when expressed as a proportion of the total in treatment, successful completions increased (from 16% to 21%).

Corresponding data for the comparison areas are set out in Table 7.6. These areas were selected purposively to be as similar as possible to the pilot areas in terms of client profile, client caseload, retention rates and funding levels. A number of issues emerge from this comparison. Despite the findings that the number in effective treatment and the number of successful completions had increased in the pilot areas, in many cases the corresponding numbers increased by more in their comparators.

Table 7.6 Effective treatment & successful completions: comparison areas						
Site	Stage	Total in Treatment	Effective Treatment	Successful Completions	E.T. as % of Total in Treatment	Succ. Comps. As % of Total in Treatment
<b>Comp 2</b>	Pre	2,425	2,229	208	91.9%	8.6%
	pilot	2,038	1,899	261	93.2%	12.8%
<b>Comp 3</b>	Pre	2,462	2,332	196	94.7%	8.0%
	pilot	2,258	2,121	395	93.9%	17.5%
<b>Comp 4</b>	Pre	5,291	4,877	800	92.2%	15.1%
	pilot	5,390	5,076	1,021	94.2%	18.9%
<b>Comp 5</b>	Pre	2,392	2,100	348	87.8%	14.5%
	pilot	2,324	2,169	571	93.3%	24.6%
<b>Comp 6</b>	Pre	1,836	1,676	155	91.3%	8.4%
	pilot	1,769	1,687	252	95.4%	14.2%
<b>Comp 7</b>	Pre	3,421	3,333	183	97.4%	5.3%
	pilot	3,049	2,903	359	95.2%	11.8%
<b>Total</b>	Pre	17,827	16,547	1,890	92.8%	10.6%
	pilot	16,828	15,855	2,859	94.2%	17.0%

The difference in differences formulae are applied to derive the estimates set out in Table 7.7, below. The columns in Table 7.7 represent the change in the proportion of clients with a positive outcome at each pilot site having made allowance, based on findings from the relevant comparison area, for what might have happened had a DSCP not been implemented there. The first two columns refer to the change in the proportion of those in treatment whose treatment is effective and the proportion of completions which are successful respectively. The third column applies the same approach but instead of relating successful completions to all completions it looks at the ratio of successful completions to the total number in treatment. The reason for doing this is that it avoids the possibility that areas might keep clients in treatment longer thereby raising the likelihood of a completion being successful.

Columns 1 and 3 of the table are the critical ones for purposes of benefit valuation since these proportions will be applied to the number in treatment in an area to make estimates of the number of additional clients whose treatment is likely (a) to be effective and (b) to translate into a successful completion.

**Table 7.7 Findings from difference in differences model**

Site	ET as % TT	SC as % TC	SC as % TT
2	-3.4%	-7.8%	-5.3%
3	+3.6%	+7.8%	+5.1%
4	+0.3%	+3.8%	-0.7%
5	-4.6%	+2.7%	+1.0%
6	-6.5%	-20.2%	-6.3%
7	+2.8%	-4.0%	-2.5%

ET denotes the number in effective treatment  
 TT denotes the total number of clients in treatment, whether or not effective  
 SC denotes the number of successful completions of treatment  
 TC denotes the number of clients completing treatment, whether successfully or not.

For purposes of estimating benefits the differences in proportions are converted back into an estimate of the number of clients involved. Table 7.8 takes the proportions from the first column of Table 7.7 and multiplies by the number of clients in treatment in the area to generate an estimate of the number of additional clients in effective treatment. These estimates can then be multiplied by an estimate of the present value of having an additional client in effective treatment (put at around £44,000 per client as developed in Appendix C6<sup>33</sup>) to get a measure of the benefits associated with each pilot.

**Table 7.8 Estimates of the number of additional clients in effective treatment**

Site	Change in % clients in treatment who are in effective treatment	Clients in treatment	Estimated change in the number of clients in effective treatment
2	-3.4%	3,169	-108
3	+3.6%	1,791	+64
4	+0.3%	3,166	+9
5	-4.6%	2,504	-115
6	-6.5%	1,841	-120
7	+2.8%	3,404	+95

The number of additional successful completions is estimated using a similar process, as in Table 7.9, by applying the difference in differences estimate (from column 3 in Table 7.7) to the total number of clients in treatment. As demonstrated in Appendices C5 and C6, the value of a successful treatment completion is potentially very high, since there is a significant likelihood (in excess of 40 per cent) that this will result in a client remaining abstinent. In this event many years of damaging behaviour may be prevented, with substantial savings to budgets in the criminal justice and health sectors. The benefit per client from these longer term benefits from continued abstinence would greatly exceed the (short term benefits) associated with having a client in treatment. However it is very difficult to produce a robust estimate for the benefit per client, although illustrative estimates are presented below.

<sup>33</sup> The benefit estimate is made by assuming, following the findings from the DTORS study, that an untreated client would be causing harm of just over £12,000 per annum more than a client in treatment. Assuming this harm reduction would continue for a four year period of treatment and discounting at a rate of 3.5 per cent per annum yields a present value per client of £44,224.

Site	Change in proportion of clients in treatment who complete successfully	Number of clients in treatment	Estimate of the change in the number of successful completions
2	-0.053	3,169	-168
3	+0.051	1,791	+91
4	-0.007	3,166	-22
5	+0.010	2,504	+3
6	-0.063	1,841	-116
7	-0.025	3,404	-85

The picture of impact which emerges from Tables 7.8 and 7.9 is mixed. In sites 3, 4 and 7 there is an increase in the number of clients in effective treatment relative to what would have been expected on the basis of changes in the comparison areas. In sites 5 and 3 there is an increase in the number of successful completions over and above what might have been expected. In contrast, sites 2 and 6 showed a drop in the numbers estimated to be in effective treatment and the number of successful completions.

The estimated benefits are volatile because they are sensitive to small changes in the proportions becoming engaged in treatment or completing treatment successfully. The very high damage costs associated with drug misuse careers create the potential for large gains from improvements in treatment or its delivery. But they also enable large 'losses' to be made in the event of performance failing to meet the improvement expected or in the event that other influences intervene. Given the complex environment in which change occurred under the DSCPs and the long time lags (known from the duration of treatment journeys), it is unlikely that benefit estimates based on the findings reported in Tables 7.8 and 7.9 would provide a reliable guide to the returns from the DSCP investment. During the two years DSCP was running the pilot sites were delivering treatment to clients at many different stages in their recovery journeys. Although substantial new numbers of clients began a treatment journey during the period and many journeys were completed it is unlikely that the longer term impact of the changes made will have been reliably expressed in the outcome measures that were tracked.

From a sensitivity analysis perspective, outlined in Appendix C6, it would make little overall difference if the benefit estimate were to be cut further. The impact of the projects would remain mixed across sites and the aggregate picture, based on the short run findings from the difference in differences model, would not change significantly.

## 7.5 Cost-benefit comparisons

This chapter has explored the costs and benefits associated with the pilots, using comparison areas as a baseline. It has also looked at other performance measures including the number of new journeys (section 7.2.1). Performance across sites has been mixed and there is only limited evidence of significant improvement in pilot areas over and above what comparison areas have achieved.

Table 7.10 combines NTA data on each DSCP's costs for each year of the project with illustrative estimates of the relevant pilot's benefits as derived from the difference in differences findings, and documented in Tables 7.8 and 7.9. These benefits estimates

make use of the valuations of (a) having an OCU as a client in effective treatment and (b) a successful completion of treatment as derived in Table C6.1 of the Appendix.

Table 7.10 Site level estimates of costs and benefits*							
	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
<b>Costs (£k)</b>							
Year 1	153	285	89	305	125	133	297
Year 2	153	256	96	139	98	140	192
Total	306	541	185	444	223	273	489
<b>Benefits (change in)</b>							
Numbers in effective treatment		-108	64	9	-115	-120	95
Successful completions		-168	91	-22	3	-116	-85
<b>Value of benefits (£k) **</b>							
Number in effective treatment		-4,767	2,853	420	-5,096	-5,294	4,217
Successful completions		-32,777	17,825	-4,325	489	-22,634	-16,607
Total benefits		-37,544	20,678	-3,905	-4,608	-27,928	-12,390
<b>Benefits: Costs</b>		-ve	112	-ve	-ve	-ve	-ve
<b>Sensitivity analysis – benefits @ 50%</b>							
Value of benefits (£k)		-18,772	10,339	-1,952	-2,304	-13,964	-6,195
Benefits: costs		-ve.	56	-ve	-ve	-ve	-ve

\* Figures have been rounded.

\*\* Using the valuations of Table C6.1 (£44,224 for a client in effective treatment for four years and £195,149 for a successful completion).

The headline findings can be summarised as follows:

Sites 2 and 6 can be excluded from further discussion because the difference in differences findings show a deterioration (relative to what would have been expected based on changes in the comparison sites) in the number in effective treatment and the number of successful completions.

Site 3 shows an improvement in the number in treatment and the number of successful completions and therefore the main issue is the scale of overall benefits; discussed further below.

Sites 4, 5 and 7 show a mixed picture. In 4 and 7 the number in effective treatment increased relative to what might have been expected but there was a deterioration in the number of successful completions, while in site 5 the position was the reverse. Using the valuations of Table C6.1 (£44,224 for a client in effective treatment for four years and £195,149 for a successful completion) and testing for sensitivity of the findings to the (estimated) unit value for benefits, the benefit:cost ratio for site 3 is as follows:

Table 7.11 Site 3 cost benefit ratio			
Site	Cost/Benefits		Total
Site 3	Benefits	64 additional clients in treatment @ £44k	£m2.853
		91 additional successful completions @ £195k	£m17.825
		<b>Total Benefits:</b>	£m20.678
	Costs		£m0.185
	Net benefits		£m20.493
		<b>Benefit:cost ratio</b>	20.49/0.185 very high (111)

The ratio for this site is very high and likely to exaggerate the benefits, as it is very sensitive to the value placed on benefits. Sensitivity checks confirm, however, that large changes such as halving the estimated benefits associated with the two outcome measures employed would make no difference to the findings.

The critical issue for the findings from all six sites is the reliability of the difference in differences results. Although a much better basis for estimates than a within-site pre-post comparison, these findings rely on outcomes at the comparison site being a compelling indicator of what would have happened at pilot sites but for implementation of DSC. There are many reasons why this assumption may be an unreliable one, and so there is inevitably a degree of uncertainty about any inferences relying upon it. There is no guarantee that events in the comparison areas will have matched exactly conditions at pilot sites. In addition, expecting improvements from DSCP to show within the lifetime of project funding is a tight criterion. The evidence, from direct observation of current NDTMS data and from earlier studies, is that many clients remain in treatment for an extended length of time before successfully completing treatment. Given that pilot areas learned at relatively short notice that they were to receive support through the DSC programme, and the inevitable lengthy delays in implementing complex changes such as an overhaul of commissioning or implementation of a SPA, it is not surprising that some of the pilot areas appeared to perform less well than their comparators who were not going through such change. It is plausible that short-term performance in relation to offending and health outcomes might deteriorate only to improve over the longer term.

The scope to draw inferences about whether some of the DSCPs worked better than others from a cost-benefit perspective is therefore limited. The nature of the changes implemented varied widely across pilot sites and the projects were multi-faceted. The result is that it would not be possible to argue that an estimate of positive benefits in one pilot would be sufficient to claim that the particular set of changes involved had been successful. Further time would be needed to track outcomes over a longer period before any confidence could be placed on the estimates of the direction and strength of impact.

In any event there remains considerable uncertainty over the scale of the benefit to be associated with successful completion of treatment. To a large extent this is attributable to the lack of information about the harm levels associated with clients who complete treatment and are not subsequently recognised as re-entrants to the CJS or treatment systems. A counterfactual for the successful completion group is difficult to establish and so the estimation of benefits for this group accordingly remains conjectural.

It is worth noting that the estimates of benefits refer to findings from a period of 18 months. To the extent that the DSCP changes were successful in bringing about long-term improvements these benefits could be expected to persist indefinitely, and this would inflate their Present Value many times over. However, it is not clear that the likelihood that the extent of change in outcomes evident over the first eighteen months can be regarded as a reliable guide to the extent of future benefits.

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## 8 Conclusion

The DSCPs were designed to explore how increased freedom and autonomy at a local level would impact on drug treatment systems. The previous chapters in this report have explored the key elements of DSCP activity, including the challenges they have faced and the facilitators and barriers to delivery. This final chapter draws together the findings, and explores the lessons that can be learnt from pilot experience in relation to:

- Local freedom and flexibility
- Continuity of care
- Personalisation
- Delivery change
- Assessing impact

### 8.1 Local freedom and flexibility

The Government's *Drug Strategy 2010* set out the intention to give local areas increased freedom to design and jointly commission services to meet the needs of service users, facilitated by pooled budgets and a move away from process-focused performance mechanisms towards a focus on outcomes. In this context, the DSCPs and the role freedoms and flexibilities played in their efforts to reconfigure treatment systems is of renewed importance, as the pilots can be viewed as early adopters of measures now being rolled out more widely. In assessing the value of the freedoms and flexibilities granted to pilot areas, it was clear that they had played a key role in some elements of pilot change. In particular, the flexibility to pool budgets and reconfigure targets had facilitated the development of integrated treatment systems. For example, the flexibility to pool CARAT funding with community-based CJS budgets had enabled pilots to create more seamless treatment systems, while freedom from process-focused targets had enabled an outcomes-focus.

However, these freedom and flexibilities were not always sufficient on their own to affect change, nor were they always a necessary foundation to reconfiguring treatment systems at a local level. For example, despite these freedoms and flexibilities, pilots' efforts to reconfigure treatment systems to improve continuity would not have been effective without the active involvement and commitment of the various treatment providers and partner agencies involved. In some cases, such as in the creation of integrated treatment systems, even with freedoms and flexibilities granted, extensive negotiations were required before all parties were confident enough to progress with the structural changes being proposed. This highlights the importance of the commitment of local partnerships to work together at all levels to affect change.

In other cases, significant change being brought about at a local level without freedoms or flexibilities from existing structures (as was the case with the SDS and SPA pilots) indicates that significant innovation can occur at a local level within the parameters that already exist. Indeed, pilot areas had sometimes requested freedoms and flexibilities in relation to perceived barriers to change, only to realise that these barriers were at a local level, and required no freedoms or flexibilities from central government. Examples of this included measures to pool local training budgets; utilise existing local funding in innovative ways; and amend data sharing protocols. The existence of perceived rather than actual barriers of this kind suggests that more work needs to be done to effectively

communicate the parameters within which local areas operate to reduce the likelihood that perceived barriers prevent innovation. It is also evident that local barriers can be resolved and progress made where local partners have a shared goal and are committed to working in partnership.

This shared vision and commitment was in large part attributed to being part of a national pilot programme. The focus and momentum that pilot status gave areas was seen as a key facilitator to affecting change on the ground. Regular project meetings, the role of the project manager, the *leverage* of being a national pilot, and the ongoing scrutiny and challenge at a regional and national level were all factors that ensured pilots maintained impetus. In some areas, the perception was that much of the pilot's activity may have happened eventually, but would have taken longer to develop and may have been narrower in scope.

“I think what this does is it focuses people a lot more and the change happens quicker than it would normally... I think [without pilot status] it would take years I think, it really would. I just think this has given it some momentum.”

(Stakeholder, Site 4, stage 2 interview)

In other areas, sites went further and said that the changes brought about by DSCP could not have happened without pilot status.

“I think we could've done piecemeal bits, so we might've been able to draw some of the providers in the community together maybe but it wouldn't have been possible to draw together the CARATs angle and all the providers together at all. It wouldn't have been possible. [There] would've been organisational barriers to that.”

(Stakeholder, Site 6, stage 2 interview)

High level stakeholder engagement at both a national and local level supported pilots in working towards change. Removing red tape, prioritising system change activities and providing clear leadership were all ways in which stakeholder engagement facilitated system change. Examples of this include one pilot area which was able to expedite planning issues in relation to creating a SPA. In another area, the ability to escalate an issue to the national project team for resolution was seen as a key facilitator to engaging with a partner agency in a way that would promote the aim of creating a coherent treatment system.

Given that this high level of partnership working and stakeholder engagement was largely attributed to being part of a pilot, a key challenge for policy makers and local areas who wish to develop innovation at a local level will be how to achieve this without the lever of “pilot status”. The 2010 Drug Strategy's commitment to fostering a more “*outcome-focused*” approach may go some way to achieving this as local partners will need to work together to maximise outcomes for service users. The challenge however, will largely depend on how an increased focus on outcomes will be realised through the commissioning and funding environment. A framework that incentivises co-operation will be crucial if local areas are to be successful in developing coherent and innovative treatment systems. The Drug and Alcohol PbR pilots currently underway represent an ideal opportunity to explore these issues.

A note of caution should be voiced in relation to the assumption that freedoms and flexibilities at a local level will necessarily improve coherence and continuity within treatment systems. What the pilots have demonstrated is that it is possible to use freedoms and flexibilities in different ways and to take various approaches to redesigning systems. While this is an advantage in encouraging innovation, one problem identified by the pilots was the difficulty of working within local and regional contexts where the new

system clashed with existing systems. With increased freedom at a local level to design drug treatment systems, there is potential for differences between localities to be exacerbated rather than reduced. In tackling continuity of care and ensuring coherent treatment systems that maximise outcomes for service users, attention must also be paid to coherence *between* localities as well as within them.

## 8.2 Continuity of care

In tackling continuity of care across the treatment system, the DSCPs identified a number of facilitators to affecting positive change. Pooled budgets, partnership arrangements and system-wide performance monitoring were viewed as important foundations to achieving continuity of care, as was strong leadership and the commitment of senior stakeholders. Workforce development including co-locating staff, joint inductions, joint training and regular meetings were also viewed as crucial to fostering cross-organisational working and integration. The fact that pilots used freedoms and flexibilities to exempt their activity from process-focused targets also indicates the extent to which targets of this kind may undermine partnership working and seamless pathways. The current move towards outcome-focused commissioning (as indicated by the PbR pilots) may go some way to tackling this issue if it incentivises providers to work together to achieve positive outcomes. However, careful consideration must be given to the funding structures established to ensure that as far as possible, co-operation is incentivised rather than discouraged.

A key barrier to continuity of care was communication. In particular, the combined difficulties of paper-based assessments and IT systems that were fragmented along the treatment pathway made implementing effective continuity of care difficult and time consuming. The pilots did find some innovative ways of reducing the impact of these issues, and the development of web-based case management systems that allowed staff across different settings to access accurate and timely information are promising developments for the future. How successful these developments are and whether a solution can be found to these issues will be critical to improving continuity of care in the long-term.

## 8.3 Personalisation

Valuable learning can be drawn from pilot activity that tailored provision to the individual needs of service users. In particular, the SPA is similar in design and ethos to the LASARS currently being developed as part of the PbR pilots. Facilitators to effective SPA delivery included independence from existing treatment providers; a central location for easy access; clearly defined referral routes; adequate levels of staffing with high quality training; and careful consideration given to onward referral routes. Ongoing challenges include ensuring that the assessment stage does not delay access to treatment, and good communication is maintained across the treatment system to ensure a seamless treatment pathway.

The SDS pilots explored the feasibility of providing a highly personalised approach to provision to improve engagement in treatment and foster a sense of self-efficacy and responsibility for their own treatment amongst service users. Because piloted on a small scale, it is difficult to assess the impact of these approaches if rolled out more widely. In addition, SDS ran parallel to existing provision, and it was beyond the scope of these pilots to put in place the contracting mechanisms that would be needed to operate a drug treatment system funded by SDS or to test specific elements like buyer groups because numbers were too small. The pilots also faced challenges in brokering a wide range of

personalised provision and the role of the service broker in sourcing services would appear vital in order to avoid delays that may impact on service user engagement. Despite these challenges the approach was felt to increase the treatment system's focus on outcomes, encourage greater use of mainstream provision and provide service users with more individually tailored support; all viewed as positive impacts. There was some feedback from sites that this form of support was most effective for service users reaching the end of their treatment journey as a way of supporting and sustaining recovery. The role SDS can play in aftercare and sustaining long-term recovery may be a fruitful area for further investigation.

## 8.4 Delivery change

Finally, alongside the structural and system change already discussed, DSCPs also made changes to delivery to re-orient their systems towards a recovery focus. The new services introduced included service user mentors, ITEP mapping, family therapy, ETE provision, housing services and mutual aid groups. In assessing the impact of these delivery changes, a key issue was the sustainability of change made. Some areas of activity including peer mentoring, fostering mutual aid and ITEP mapping were fully embedded in pilot sites, while other elements of delivery change appeared more vulnerable. This was in part because they required additional resources (in the case of family therapy), or relied on effective partnerships (for example with JCP) which were vulnerable to retrenchment due to economic austerity. Small in scale, and delivered alongside other elements of pilot activity, it is difficult to assess the value and impact of these changes to pilot delivery. Further systematic evaluation and large scale piloting is required to explore their impact more fully.

## 8.5 Assessing impact

The aim of the pilot programme was to encourage innovation and change in drug treatment systems at a local level. The result was the delivery of seven distinct pilots trialling different approaches, combining different elements of pilot activity and seeking to achieve different outcomes. While this complexity provides a rich opportunity to explore a range of alternative approaches and to test the hypothesis that local freedom will lead to innovation and improve outcomes, it also poses real challenges to evaluating impact. In particular assessing impact was limited by timescales, data sources and pilot complexity, discussed in turn here.

- Outcome data sources

To minimise the burden on pilot sites to collect additional data for research purposes, the evaluation relied on existing administrative data. Missing data, small sample sizes at local pilot area level, and limitations on the type of data routinely collected meant outcomes that would be of interest to the evaluation could not be tracked. Re-conviction rates and impacts on housing and ETE were some of the outcomes that were not included in the evaluation for these reasons.

- Attributing impact

It was not uncommon for pilot areas to be trialling a range of different activities and this complexity meant impacts that were detected could not be attributed to a specific element of pilot activity. This limited the extent to which firm conclusions could be drawn about the relative merit of each element of pilot activity.

- Timescales and observing impact

The long average duration of a new treatment journey (four years<sup>34</sup>) means the impact of pilot activity on outcomes may not be visible for a number of years to come. Pilot areas also spoke of the “*strain of change*” that was associated with significant upheavals within the treatment system and delays in getting the new systems fully functioning. Consequently, the full range of impacts from the pilots and the associated returns to investment will not be visible for some time to come.

To return to the original aims of the DSCPs – to encourage local innovation and improve drug treatment outcomes, the evidence from the evaluation would suggest that the programme was successful in encouraging and facilitating local areas to trial new approaches. Ambitious programmes of change were implemented which have wider application and lessons can be learnt from these experiences. In terms of improving drug treatment outcomes the analysis of administrative data and the economic impact analysis provides a mixed picture, however, given the caveats discussed above, these findings should be treated with caution. Longer term follow-up to track the impact of the pilots beyond the end of the pilot period would provide valuable insight into the longer term impact of this innovative pilot programme.

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<sup>34</sup> The evidence is that “*for clients who go on to sustain their recovery, their treatment journeys span an average period of four years*” (NTA, 2011, p18), which refers also to evidence from an earlier study by Best et al. (2006). In many instances this will include more than a single new treatment journey.

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## Appendix A      Qualitative topic guides

Example topic guides used with staff and service users in the qualitative case studies, indicating the main areas discussed, are provided below. Detailed prompts and probes have been omitted.

### **Service user topic guide (Stage 3)**

**Specific objectives of the stage three interviews with service users:**

- To explore the treatment experiences of service users
- To track change over time for service-users as they progress through their treatment
- To identify strengths and weaknesses of DSCP activities from the perspective of service users
- To explore impacts of treatment provision on service users and identify which elements of DSCP are felt by service users to have positive / negative impacts

#### **1. Introduction**

*Aim: To introduce the discussion, NatCen and purpose of interview*

- Introduce self & NatCen
- Introduce research and aims of study & interview
- Explain
  - Independence of NatCen
  - Voluntary participation
  - Written consent
  - Brief overview topics to be covered (conversational in style)
  - Length (about 45 mins – 1 hour)
  - Confidentiality (including potential caveats)
  - Audio recording (including data storage and data protection issues)
- Opportunity for questions

#### **2. Background and drug use history**

*Aim: to find out contextual information about their current circumstances*

- General background
- Drug using history

#### **3. Drug treatment experiences**

*Aim: To examine previous drug treatment experiences for context and to assist researcher with comparison between pre and post DSCP provision / experiences, and to gather an update on current treatment experience.*

- Brief re-cap of previous treatment history (confirming detail from previous interview)

- Nature of any changes to drug treatment services accessed since last interview

## **5. Current DSCP services**

*Aim: to focus on the specific DSCP changes taking place in the area and how these have been experienced by service users since previous interview.*

*[Sub-sections in this section relate to specific 'changes' taking place in the DSCP sites. For each site focus on the sub-sections that are relevant to the pilot area.]*

### **Continuity of care**

#### **Within CJS**

- Update on experiences of continuity of drug treatment from community to custody
- Update on experiences of continuity of drug treatment from custody to community
- **Continuity across partnership boundaries**
  - Experience of transfer from out-of-area prisons into local community-based services
  - Experience of transfer from other localities into local community-based CJS services
  - Comparison of experiences of within and out of area transfers
- **Between community services**
  - Experiences of continuity of drug treatment between community services e.g. between prescribing, psychosocial services, structured day programmes

### **Case management**

- Update on nature of case management
- Ongoing views and experience of case manager role
- Facilitators and barriers to successful case management

### **Single Point of Assessment**

- Update on services accessed via SPA
- Views on appropriateness of services available
- Suggestions for other services currently not included
- Views on accessibility of building
- Update on assessment process and any subsequent reassessments since previous interview
- Added value of having a single point of access to services

### **Self directed support**

- Update on services accessed via SDS since last interview
- Update on any further assessment processes involved in SDS since last interview
- Update on role of key worker / care coordinator
- Update on role of personalised support plan
- Process of picking and accessing services

- Added value of SDS compared to previous experiences

### **Services accessed**

- Update on range of services accessed
  - Peer mentoring (both as mentor and mentee)
  - Family conferencing / therapy
  - ETE support
  - Housing support
  - ITEP/BTEI
  - Mutual aid
- Update on experiences of these services

### **6. Impact of DSCP on treatment experiences**

*Aims: to focus on what impact DSCP changes have had on their treatment experience to date, following up on outcomes identified in Stage 2 and also identifying any additional outcomes since then.*

- Views on current treatment – level of satisfaction
- Impacts of current treatment
- Factors that contributed to impacts
- Views on any areas of unmet need
- Future plans

### **7. Next steps**

*Aims: To discuss any other areas or questions the participants want to discuss and let them know who to contact for further information*

- Any other areas of importance to cover
- Any questions now for research team
- Reassure confidentiality
- Thank them for their time. Tell them that they are welcome to contact members of the research team (address on leaflet) to ask questions at a later date if they wish.

## **Staff topic guide (Stage 3)**

### **Specific objectives of the Stage 3 interviews with stakeholders and delivery staff:**

- Reflect on experiences of DSCP as pilot period draws to an end
- Explore progress made and lessons learnt
- Explore nature of impacts and facilitators and barriers to these
- Explore future plans

### **1. Introduction**

*Aim: to remind the participant about the aims of the study, explain how the interview will be conducted, and how the data collected will be used.*

- Introduce self and NatCen
- Reiterate the aims of the study
  - Confidentiality and how findings will be reported
  - Make clear here the formative nature of the evaluation and the intention to report to the Management Board
  - Explain that aim is to ensure that learning is disseminated between pilot sites to facilitate good practice
  - Sites will not be named in report, but potential caveats to anonymity
  - Anonymised quotes will be used
  - length of interview – 1.5 hours

### **2. Professional Background**

*Aim: to understand the participant's professional role [very brief as this will have been covered in previous interviews]*

- Re-cap of role and organisation worked for
- Nature of any changes in role in relation to DSCP since previous interview

### **3. Overview of drug system change pilot activity**

*Aim: to briefly contextualise the discussion by re-capping the main aims and components of pilot activity*

*Note to researcher: to be covered very briefly to re-cap as will have been discussed in detail at previous stages*

- Re-cap aims of DSCP
  - what pilot is trying to achieve
  - anticipated outcomes and impacts
  - theory of change
- Overview of main DSCP activities

### **4. Pilot implementation and management: reflections and learning**

*Aim: to gather stakeholder reflections on the implementation and management of the pilot over its lifetime. To identify changes to implementation and management over the two year pilot period and the reasons for this.*

- Pilot management
- Timescales

- Funding

## **5. Continuity of care [discuss only with pilot areas tackling this issue]**

*Aim: to map how drug system change activities have impacted on continuity of care within the treatment system. To assess progress made by pilot areas in relation to continuity of care by the end of the pilot period. Identify key barriers and facilitators to achieving change in this area. Identify*

- Progress of key pilot activities that have facilitated continuity of care:
  - Commissioning
  - Funding
  - Management structures
  - Governance and performance management
  - Information systems
  - Case management
- Assessment of progress made during lifetime of pilot
- Future plans

## **6. Personalisation**

*Aim: to map how drug system change activities have impacted on personalisation. To assess progress made by pilot areas in relation to personalisation by the end of the pilot period. Identify key barriers and facilitators to achieving change in this area. Explore future plans in relation to this.*

- Self-directed support
  - Nature of changes implemented to facilitate SDS
  - Funding
  - Assessment and referral processes
  - Case management
  - Management structures
  - Governance and performance management
- Single point of assessment
  - Re-cap key elements of SPA model
  - Funding
  - Assessment and referral processes
  - Case management
  - Management structures
  - Governance and performance management
- Personalisation: assessment of progress made during lifetime of pilot
  - Key facilitators to achieving personalisation
  - Key barriers to achieving personalisation
  - Assessment of progress during pilot period
  - Anything they would have done differently
    - Barriers
- Future plans

## **7. Changes to service delivery**

*Aim: to map how drug system change activities have changed delivery of mainstream and wrap-around services. To assess progress made by pilot areas in relation to delivery*

*change by the end of the pilot period. Identify key barriers and facilitators to achieving change in this area. Explore future plans in relation to this.*

- Peer mentoring
- Housing services
- ETE services
- Family therapy
- ITEP/BTEI
- Mutual aid

### **8. Drug System Change Outcomes and Impacts**

*Aim: to explore the nature of pilot impacts and outcomes as pilot period draws to an end. To identify which areas of pilot change were felt to have the greatest impact and why.*

*Explore*

- Impact on treatment systems
- Impacts on service delivery
- Impacts on service users
- Measuring impact of DSCP

### **9. Drug System Change Pilot added value**

*Aim: to explore the added value of pilot activity*

- Assessment of added value of DSCP
- Key learning from participation in DSCP

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## **Appendix B      Quantitative analysis technical appendix**

This appendix outlines the methodology used for the quantitative evaluation. It provides more detail on methods and data used to construct the outcomes and the statistical comparisons that were made.

### **B1. Data sources and outcome indicators**

During the early stages of the evaluation, discussions with various Government departments took place to explore which databases would best capture the target population and the possibility of tracking clients' treatment journeys as they moved between community treatment and the CJS. Discussions regarding the Drug Data Warehouse (DDW) data suggested that this would be unlikely to be available for both the pre-pilot (baseline) and pilot period within the evaluation timeframe. Linking databases for the purpose of the evaluation was similarly unfeasible. The option of using re-offending data as an outcome measure was also explored, however, access to PNC data was not granted for the evaluation.

The NTA's TOP data was explored as a potential source of outcome measures. TOP data includes self-reported information that is updated during the client's treatment journey including drug use, offending, housing need, ETE undertaken, and physical and psychological health. The self-reported offending information presented a possible alternative way of measuring re-offending. Unfortunately, due to low TOP compliance in the pre-pilot (baseline) period, the sample sizes available at local pilot area level were insufficient for quantitative analysis of client outcomes. Thus some statistics routinely presented at a national level based on TOP data, such as change in housing need, could not be replicated for pilot areas due to the small number of clients involved.

The focus by some DSCPs on offenders as a target group also raised the challenge of coverage and reliably identifying the target groups within the databases used. For example, using the NDTMS referral source to identify offenders is acknowledged to be unreliable. Linking to other databases (e.g. DIMIS or probation service data) could provide more reliable ways of identifying the target group. Data analysts at the NTA are involved in some routine linking of NDTMS data with DIMIS and assisted with the identification of clients referred to treatment by DIP using their NDTMS. However, offenders entering treatment from other CJS sources, e.g. those on community orders with a DRR are still likely to be underrepresented in the offender subgroup used in our analysis.

As a result of these challenges DIMIS was used to measure continuity of care for clients transferring out of prison to DIP, aggregate data produced by NTA analysts to measure continuity of care for clients referred by DIP to community treatment and NDTMS core data to measure effective treatment and successful completions.

## B2. Quantitative analysis methodology

There were three strands to the quantitative analysis:

- data from DIMIS was used to measure continuity of care for clients transferring out of prison to the DIP;
- quarterly DIP to NDTMS reports produced by NTA analysts were used to measure continuity of care for clients referred by the DIP to community treatment; and
- core data from NDTMS was used to measure effective treatment and successful completions.

In each case, the analysis focused on comparing outcomes over two 18 month periods. The DSCPs began on 1st April 2009 and ran until 31st March 2011. To account for delays in the commencement of pilot activity as a result of their complexity, the results discussed here exclude the first six months of the two year pilot period. The timeframes under examination are therefore the 18 month period prior to implementation (1st October 2007-31st March 2009) and the last 18 months of the programme's operation (1st October 2009-31st March 2011).

### **Continuity of care from prison CARAT services to CJIT**

Data from the DIMIS database was used to measure continuity of care for clients transferring out of prison to the DIP. Extracts of the relevant tables from DIMIS were obtained from the Home Office for the two periods of interest. The key tables of interest (from the database) were CARAT AF5 and CJIT AF5 and AF7.

The analysis was based on CARAT referrals from prisons to CJIT. In the pilot areas, only referrals from the pilot prison were considered. In the comparison areas, referrals from any prison in the area were included as long as the client was recorded as living in the local DAT area. In both cases the interest was in *local* referrals only. In other words, if the client was referred to a CJIT team in a *different* locality (DAT) then the referral was not included in the analysis.

For each referral, the analysis attempted to find a matching CJIT pick up i.e. it looked for a CJIT form with a matching prison code and a care plan date up to (but not exceeding) 42 days after the prison leaving date. The analysis was therefore restricted to referrals (recorded on CARAT AF5) between 1st October 2007 – 17th February 2009 (pre-pilot) and 1st October 2009 – 17th February 2011 (pilot period).

In order to identify the matches, data from CARAT AF5 was matched to CJIT AF5 and AF7 forms for the whole period; the period 18<sup>th</sup> February - 31st March inclusive allowed six weeks for referrals to be picked up by CJIT. Where a matching pick up was found, the referral was classified as “successful”.

The above procedure was carried out for each of the six pilots and their corresponding comparison areas in each of the two periods of interest. This yielded six sets of four success rates (percentages of successful referrals) which were analysed using a difference in differences approach to compare the changes in the percentage of successful referrals.

In each case, the *change* in the percentage of successful referrals between the pre-pilot period and the pilot period (found by subtracting the former from latter) in the comparison area was subtracted from the corresponding change in the pilot area. This gave the percentage improvement that occurred in the pilot over and above that which occurred in the comparison area. This estimates the improvement (or decline) that is attributable to

the pilot programme, as the change in the comparison area is assumed to estimate the change that would have occurred in the pilot area had the pilot not taken place.

The difference in difference analysis was also carried out at the referral level using logistic regression models which allowed us to assess the statistical significance of the changes whilst controlling for client characteristics; whilst the comparison areas were carefully chosen to match the pilot areas, particularly in the demographic profile of clients, it was nevertheless prudent to control for client characteristics where possible. The following variables (derived from the information taken from the latest DIR) were included in these models:

- Age and sex
- Ethnicity
- Drug taking: PDU (Opiates and Crack)
- Drug taking: Cannabis
- Drug taking: Stimulants (Cocaine and amphetamines)
- Drug taking: Other (including prescription)
- Length of drug use
- No fixed abode flag
- Treatment: in current treatment or treated in the last two years

These variables were thought to cover the key (potential) confounding factors that could affect the outcomes in question. Where data was missing (all variables apart from age and sex), separate missing categories were created (for each variable) so that the analysis included the full base of clients.

### **Continuity of care from CJIT to community**

Quarterly DIP to NDTMS reports produced by NTA analysts were used to measure continuity of care for clients referred by DIP to community treatment. These data in the form of spreadsheets containing aggregated counts for each DAT were available by quarter. The counts of interest were: number of clients with DIP referrals (during the quarter); and number (of these) triaged within six weeks of referral.

The format of the spreadsheets changed in December 2007 such that the maximum gap between referral and triage for the client to be counted as successfully referred was reduced from 12 weeks to six weeks. This meant that the first useable quarter was December 2007 – February 2008. The quarters did not match up perfectly with the period of interest (the latter ending in March rather than February), therefore the analysis was restricted to the periods December 2007 – February 2009 and December 2009 – February 2011.

In each case counts from five quarters of data were summed across the relevant DATs to obtain totals from which the percentages of clients triaged within six weeks of referral during each 15 month period were calculated.

These percentages were then analysed using difference in differences (as described above) to measure the percentage improvement that occurred in each pilot area over and above that which occurred in the corresponding comparison area. Changes in the base number of clients referred were also analysed using the same approach. In both cases, as the data was only available at the aggregate level, it was not possible to control for client characteristics.

## Effective treatment and successful completions

Two extracts from NDTMS were obtained from the NTA. In each case the data comprised all client journeys crossing into the period of interest. The analyses were based on a client's latest journey within the period. All clients aged 18+ were included in the analysis. The two outcomes are defined as follows.

### Effective treatment

A client was in effective treatment if the journey exit reason indicated that treatment had been completed or the journey length (up to the end of period) was greater than or equal to 83 days. If the journey ended within the period of interest, then the full journey length was calculated i.e. the number of days between the journey start date<sup>35</sup> and the journey end date. If the journey ended after the end of period (i.e. after 31<sup>st</sup> March 2011 in the case of the pilot period or 31<sup>st</sup> March 2009 for the pre-pilot period) or was missing, the days between journey start and the end of the period were used.

The client was in effective treatment if the journey exit reason was one of the following:

- 1 Treatment completed drug free
- 2 Treatment completed
- 15 Completed drug free - referred to targeted youth support services (YP code)
- 16 Completed drug free - referred to child looked after services (YP code)
- 17 Completed drug free - referred to criminal justice service (YP code)
- 18 Completed drug free - referred to health or mental health service (YP code)
- 19 Completed drug free - referred to adult treatment provider (YP code)
- 20 Completed drug free - referred to other adult service (YP code)
- 21 Completed drug free - referred to no agreed lead agency (YP code)
- 22 Completed - referred to targeted youth support services (YP code)
- 23 Completed - referred to child looked after services (YP code)
- 24 Completed - referred to criminal justice service (YP code)
- 25 Completed - referred to health or mental health service (YP code)
- 26 Completed - referred to adult treatment provider (YP code)
- 27 Completed - referred to other adult service (YP code)
- 28 Completed - referred to no agreed lead agency (YP code)
- 80 Treatment completed drug free (CDS-F)
- 81 Treatment completed (alcohol free)
- 82 Treatment completed - occasional user (not opiates or crack)

or the journey length calculated above was greater than or equal to 83 days

The percentage of clients in effective treatment was therefore calculated as follows:

$$\frac{\text{Clients in effective treatment}}{\text{Clients with a treatment journey crossing into the period}} \times 100\%$$

### Successful completions

If the latest journey ended within the period i.e. between 1<sup>st</sup> October 2009 and 31<sup>st</sup> March 2011 (in the case of the pilot period) and the journey exit reason was one of those listed above (indicating that treatment had been completed) then the client was deemed to have had a successful completion. The percentage of clients with successful completions was therefore calculated as follows:

<sup>35</sup> For this measure, journey start dates were restricted to be no less than 83 days before the end of the period i.e. before 7<sup>th</sup> January, to allow the potential for at least 83 days of continuous treatment.

$$\frac{\text{Clients successful completions}}{\text{Clients with completions (successful or otherwise)}} \times 100\%$$

For each of the two outcomes, the differences in differences over time between each pilot and its comparison were calculated. As with continuity of care, these provided a measure of the percentage improvement that occurred in each pilot over and above that which occurred in the corresponding comparison area.

As with continuity of care, the difference in difference analysis was also carried out at the client level using a logistic regression model to assess the statistical significance of the changes whilst controlling for client characteristics. In this case, the following (derived) variables from NDTMS were included in the models:

- Age and sex
- Ethnicity
- Drug taking: PDU (Opiates and Crack)
- Drug taking: Cannabis
- Drug taking: Stimulants (Cocaine and amphetamines)
- Drug taking: Other (including prescription)
- Length of drug use
- Criminal Justice referral
- Previously treated
- Dual diagnosis

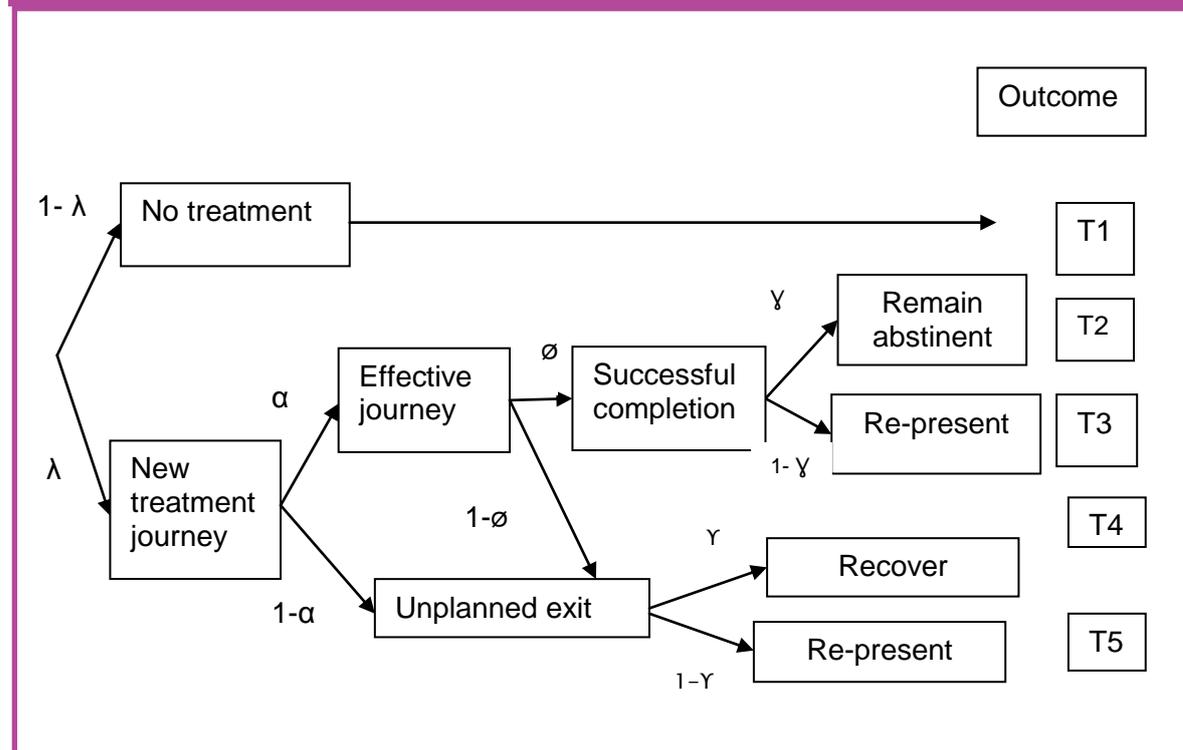
These variables were thought to cover the key (potential) confounding factors that could affect the outcomes in question. Where data was missing (all variables apart from age and sex), separate missing categories were created (for each variable) so that the analysis included the full base of clients.

## Appendix C Economic evaluation

### C1. Treatment pathways and outcomes

Figure C1.1 characterises the principal treatment pathways. The proportions following each pathway can change with various parameters including client behaviour, treatment management and the substantive content of treatment. The DSCP programme involves DATs changing aspects of their systems for managing treatment. The returns to the DSCP programme depend on the degree to which DATs succeed in influencing parameters  $\alpha$  (the proportion of treatment journeys which are effective),  $\emptyset$  (the proportion of effective treatment journeys resulting in a successful completion), and  $\Upsilon$  and  $\Upsilon$  (the proportions of completions resulting in continued abstinence). Funding conditions will be the principal influence on the proportion ( $\lambda$ ) of OCU's embarking on a new treatment journey.

Appendix Figure C.1.1 Outcome pathways and likelihoods



A proportion  $\lambda$  of OCU's embarks on a new treatment journey

Of these new journeys a proportion  $\alpha$  are effective

A proportion  $\emptyset$  of effective treatment journeys results in a successful completion, with the result that a proportion  $\beta (= \alpha * \emptyset)$  of new journeys results in a successful completion

A proportion  $\Upsilon$  of successful completions result in continued abstinence

A proportion  $\Upsilon$  of unplanned exits result in recovery

The benefits associated with terminal nodes (or ends of pathways) T2 -T5 are measured by reference to the 'no treatment' node or outcome, T1.

The mechanics of the adjustment of stocks and flows of clients in treatment are explored in greater depth in Appendix C3.

## C2. Cost-benefit framework

This section considers in greater detail the considerations informing the framework required for a cost-benefit analysis<sup>36</sup>.

The DSCP programme was concerned with the whole system for delivering drug treatment rather than with the substantive content of treatment. This has important implications for the analytical framework required, including the time profile of project costs and benefits. It is important to document the impact of the programme on delivery measures (such as the degree of co-ordination in handling referrals between custody and community) as well as on treatment outcomes (such as abstinence rates or reduced offending). While the latter will be the source of substantive benefits in the final analysis, the logic of the programme is such that there are various early delivery-based indicators which can be used to detect impact before the crime reduction, health improvement and other effects emerge.

An important difference between the cost-benefit calculations here as compared with those developed for other studies of drug treatment is that we are exploring the impact of a once-for-all change. Insofar as the changes are self-contained and discrete they involve project costs for the two year duration of DSCP but do not entail a continuing higher level of expenditure thereafter. So, although the resources used in the project were 'current' spending on staff salaries and so on, they really represent a form of 'investment' spending over two years expected to deliver continuing benefits in the future. The costs of treatment services themselves, by contrast, will continue so long as treatment is provided.

The long average duration of a new treatment journey will play a major role in delaying evidence of longer term benefits. Recent analysis shows that the average treatment journey lasts around four years<sup>37</sup>. This has two important implications. First, it will take a longer time than was available for this research for the full benefits to emerge. Second, by tracking some of the intermediate measures, such as the ratio of new journeys to the stock of OCUs in treatment, it may be possible to identify leading indicators of a longer term improvement in offending, health and related substantive outcomes.

For purposes of estimating impact over the shorter term, there are various measures that can be used as a proxy for the volume of treatment being delivered. These include the number of OCUs in effective treatment, treatment exits (measured monthly) and new treatment starts. However, it is important to be aware that in projects involving a degree of physical upheaval (such as major construction work) or significant training or workforce development there may be a temporary interruption to new client journey recruitment as changes are implemented, so it is possible that volumes will decrease initially before increasing later on.

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<sup>36</sup> For broader discussion see Bowles (2010).

<sup>37</sup> The evidence is that *"for clients who go on to sustain their recovery, their treatment journeys span an average period of four years"* (NTA, 2011, p18), which refers also to evidence from an earlier study by Best et al. (2006). In many instances this will include more than a single new treatment journey.

For purposes of assessing the return achieved on the investment into the DSCPs, it is necessary to estimate the monetary benefits from the programme for comparison with programme costs. In order to monetise the benefits from public investment in drug programmes empirical measures are required of the degree to which various outcomes (such as reduced offending or improved health) are delivered. Recent work by NTA, as exemplified by the Value for Money (VfM) model available via the home page of NDTMS<sup>38</sup>, is facilitating this task but challenges remain.

The time frame over which benefits are expected to extend is an important part of the calculation. While the costs of implementing the programme are incurred during the first two years (years 1 and 2) the benefits may continue to accrue indefinitely, since improvements to a delivery system may represent a once-for-all change that raises the productivity of the system and enables a permanent increase in its efficiency.

The pilots were launched at short notice and many of them took considerable time to implement. In addition, the turnover of clients in treatment is relatively slow. Improving treatment system efficiency, for example by reducing the average length of time in treatment, will accordingly take a number of years. The expectation therefore is that an implementation lag will have meant that the full range of benefits will not have come into play much before the end of project funding. With implementation during years 1 and 2, benefits might continue to grow over years 4 to 5 and beyond on this analysis. At the time of writing an important component of the returns to the investment remains unrevealed.

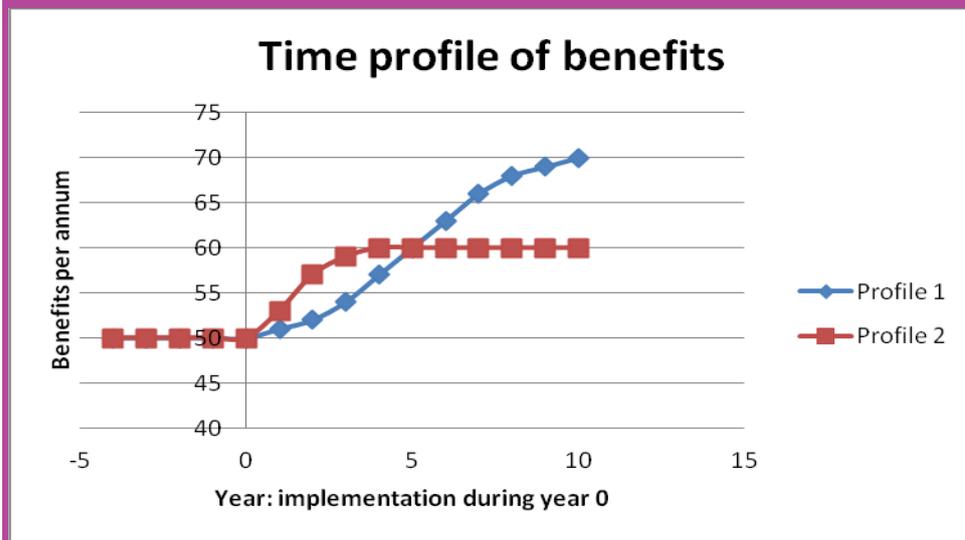
The treatment pathways illustrated in Figure C1.1 will in many cases be long; it is well established that clients will typically be in treatment for four years and sometimes longer (NTA, 2011). Since the most substantial benefits can be expected once clients become abstinent, there is inevitably a time lag before the impact of intervention can be discerned.

Figure C2.2 provides a simplified picture of two possible time profiles for benefits. In profile 2 the principal benefits occur early on and reach a new steady state after four years. In profile 1, factors such as implementation delays and slow turnover of the stock of clients in treatment limit adjustment during the first five years early stages but the changes ultimately result in a larger increase in steady-state benefit levels.

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<sup>38</sup> [www.ndtms.net](http://www.ndtms.net)

Appendix Figure C.2.1 Illustrative example of the time profile of benefits



In the short term, while the changes are being introduced, the benefits may appear to be accumulating only rather slowly if at all since new treatment journeys comprise only a relatively small proportion of the total stock of clients in treatment in an area. The ‘pay-back’ period on DSCPs may therefore be comparatively lengthy even though there may be substantial benefits over the longer term. Incurring up-front costs to move to a more systematic triage and assessment process as new journeys begin, for example, may enable treatment targets and service choices to be better informed. This may in turn enable successful completion of treatment in a higher proportion of cases and possibly enable a reduction in the average duration of a treatment journey. In the longer term this will enable more clients to be treated within the same budget and deliver greater benefits since a higher proportion of an area’s OCU’s will be in treatment and a higher proportion will exit and remain potentially drug free.

The logic of the change the pilots were intended to bring about is more indirect than for many interventions. The pilots did not set out to change the substantive content of treatment directly as much as the systems through which treatment is delivered. It is likely therefore that the changes will take longer than usual to work through to result in treatment outcomes. For example a move to a more outcomes-based focus for treatment requires significant lead in time.

### C3. Sources of benefits

#### Model

At the end of year 0 there is a stock of clients in treatment,  $S_0$ . A year later this stock can be partitioned into 3, comprising:

$$S_0 = x_1^s + y_1^s + z_1^s$$

Where:  $x_1^s$  denotes (the flow of) planned exits during year 1 from the opening stock of clients at the start of the year

$y_1^s$  denotes (the flow of) unplanned exits within 12 weeks of starting a journey from the opening stock of clients at the start of the year

$z_1^s$  denotes the stock of clients who had been in the opening stock at the start of the year and remain in treatment at the end of the year

During year 1 the opening stock is augmented by a flow of clients beginning a new treatment journey.

$$J_1 = x_1^j + y_1^j + z_1^j$$

This flow,  $J_1$ , comprises three components, namely:

$x_1^j$  (the flow of) planned exits during year 1 from the flow of clients beginning new treatment journeys during the year

$y_1^j$  (the flow of) unplanned exits within 12 weeks of starting a new treatment journeys during the year

$z_1^j$  the stock of clients starting a new treatment journey during the year who remain in treatment at the end of the year

From these definitions of stocks and flows it is possible to derive expressions for other variables. In particular we define:

1. Number in effective treatment during year 1,  $T_1$ , which is given by:

$$T_1 = S_0 + J_1 - y_1^s - y_1^j$$

This gives the total in treatment at the start of the year plus new journeys started during year 1 less unplanned exits (from either the initial stock or clients starting new journeys).

2. Number of successful treatment completions during the year (the number of planned exits from treatment) which is given by:

$$X_1 = x_1^s + x_1^j$$

In terms of the NTA's VfM model these two variables represent the principal drivers of benefits derived during year 1, namely:

#### **Driver 1: Benefits from retaining clients in effective treatment**

The benefits arise because this group offends less and enjoys better health than OCUs who have not entered effective treatment. Denoting the benefits per client for this group as  $B_1$ :

$$\text{Driver 1 benefits} = B_1 * T_1$$

#### **Driver 2: Benefits from planned exits from treatment.**

Of these  $X_1$  planned exits some proportion,  $\emptyset$ , will remain abstinent indefinitely while the remainder will re-present with offending or health related drug issues within some number of years. The benefits for the abstinent group (denoted  $B_2$  per client) will be greater than those for the re-presenting group (denoted  $B_3$  per client), with the result that total benefits for driver 2 are given by:

$$\text{Driver 2 benefits} = (\emptyset B_2 + (1 - \emptyset) B_3) * X_1$$

From the data in the public domain on the NDTMS website it is unfortunately not possible to recover the values ( $\emptyset$  and  $X_1$ ) for individual DATs that would be needed to assess the value of benefits being delivered by treatment (or the change in benefits

attributable to some change in policy). However such an analysis is reported in Chapter 7 based on (anonymised) site-level data from NDTMS.

## C4. Difference in differences model and the valuation of benefits

The purpose of the model is to support the derivation of an estimate of the impact of the DSCPs. The benefits are directly proportional to the increase in the numbers in effective treatment and the numbers of successful completions relative to what would have occurred in the absence of the Programme. Notation:

$X^C, X^P$  Number in treatment in comparison area (C) and pilot area (P)

$Y^C, Y^P$  Number in effective treatment in comparison area (C) and pilot area (P)

$Z^C, Z^P$  Successful completions of treatment in comparison area (C) and pilot area (P)

Time is indexed by a subscript t taking values 0 (pre-intervention) and 1 (post-intervention).

The first step is to compute, for both pilot and comparison areas, (a) the proportion (of clients in treatment) whose treatment is effective and (b) the proportion of those in treatment who complete successfully. Increases in either ratio potentially contribute benefits. The purpose of the difference in differences approach is to control for the possibility that these ratios would have improved spontaneously in the pilot areas in the absence of DSC implementation. The proportions, using the superscripts P and C to indicate area and the subscripts 0 and 1 to indicate pre- or post-implementation, are denoted as  $\alpha$  and  $\beta$  respectively.

### Definitions

	Pilot		Comparison	
	Pre	Post	Pre	Post
Number in treatment	$X_0^P$	$X_1^P$	$X_0^C$	$X_1^C$
Number in effective treatment	$Y_0^P$	$Y_1^P$	$Y_0^C$	$Y_1^C$
Successful completions	$Z_0^P$	$Z_1^P$	$Z_0^C$	$Z_1^C$
Proportion in effective treatment	$\alpha_0^P$	$\alpha_1^P$	$\alpha_0^C$	$\alpha_1^C$
Proportion completing successfully	$\beta_0^P$	$\beta_1^P$	$\beta_0^C$	$\beta_1^C$

Definitions (examples, based on pilot area, pre-DSC):

Proportion in effective treatment (pilot area, pre-DSC):  $\alpha_0^P = Y_0^P / X_0^P$

Proportion completing successfully (pilot area, pre-DSC):  $\beta_0^P = Z_0^P / X_0^P$

Difference in differences:

$$\begin{aligned} \text{Effective treatment:} & \quad [\alpha_1^P - \alpha_0^P] - [\alpha_1^C - \alpha_0^C] \\ \text{Successful completions:} & \quad [\beta_1^P - \beta_0^P] - [\beta_1^C - \beta_0^C] \end{aligned}$$

From these proportions it is possible to estimate for each pilot area the change in the number in effective treatment and the number of successful completions attributable to DSC. These estimates are then transformed into estimates of project benefits by exploiting estimates of the monetised benefits per capita associated with entry into effective treatment and with successful completion of treatment.

Benefits from DSC:

Effective treatment: 
$$[(\alpha_1^P - \alpha_0^P) - (\alpha_1^C - \alpha_0^C)] * X_1^P * B^A$$

Successful completions: 
$$[(\beta_1^P - \beta_0^P) - (\beta_1^C - \beta_0^C)] * Z_1^P * B^B$$

Where  $B^A$  is benefit per OCU in effective treatment

$B^B$  is benefit per successful completion

For purposes of applying the model:

- the values of alpha and beta are computed from NDTMS data for the pilot and comparison areas;
- the observed values of the number in treatment and the number of successful completions in the pilot areas are used; and
- the benefits per client are estimated using the methodology outlined in Chapter 6.

## C5. Estimating harm levels

The NTA (2011) study is based on a model of careers of substance misuse that typically span 20 years. The career is split further into three parts. During the first 8 years an individual becomes an OCU, imposing substantial costs principally in the form of offending and use of health and social care services. The next four years involve treatment, whether continuously or in the form of a number of separate treatment journeys. Some proportion of clients, having successfully completed treatment, remain abstinent for the remaining eight years of the 20 year career, making no further contact with the CJS. Others, however, do not maintain recovery and return to OCU status.

The returns to drug treatment come in two parts. First there is a harm reduction effect (the size of which was estimated in DTORS) during the four years or so clients are in treatment. Second there is a harm reduction effect over a further eight or so years provided that the client remains abstinent. The key assumptions are set out in Table C5.1 and estimates of the value of treatment are summarised in Appendix C6.

Appendix Table C.5.1 Harm levels associated with outcomes

Pathway terminus	Short run	Long run
T1: Not in treatment		
	£55,127 in first year of treatment (DTORS) (£4,543 health costs + £50,585 crime costs)	Lifetime: £768,214 (prob based on PricewaterhouseCoopers (2008)) estimate of £736,000 for a 21 year old male, derived in turn from Godfrey, 2002, estimates): alternatively use the DTORS finding applied to the remainder of a misuse career (£55,000 p.a. for 8 or possibly 12 years)
T2 & T4: Remain abstinent		
	Average cost while in treatment: £43,087, comprising: Offending costs of £39,967 (down from £50,585) + Health costs: £3,120 (down from £4,543) Lost output: ignored Result is Saving relative to no treatment of £12,041 p.a.	Likelihood (planned exit): 53% Likelihood (unplanned exit): 41% Assume either that all harm stops at the point of successful completion of treatment or that it tapers in some way over the remaining 8 years post-treatment
T3 & T5: Re-present to CJS		
	As for T2 and T4	Likelihood (planned exit): 53% Likelihood (unplanned exit): 41% Assume either that harm goes back up to the DTORS pre-treatment level or that it decays spontaneously over the remaining years of the misuse career

Source of data: Table 9 (p26) of DFE (2010) for DTORS estimates.

An analysis of the principal pathways through treatment, identifying the terminal nodes T1 to T4, is presented in Appendix C1.

## C6. Estimates of the value of treatment

The net result of making the assumptions set out in C4 is that a Present Value can be estimated as follows. The short term benefits of referral for treatment, based on the DTORS estimate of £12,041 pa, are assumed to extend for four years. Applying a discount rate of 3.5% p.a. gives a harm reduction impact of around £44,224 as compared with treatment costs of around £3,000 pa. This results in a Net Present Value of around £33,215 for the short term benefits of being in effective treatment: see further Table C6.1.

Over the longer term, however, the benefits are potentially greater in the event of continued abstinence. If it is assumed, following NTA findings, that 46% of clients who do not reappear in either criminal justice or treatment datasets have desisted from substance misuse and offending entirely since completing treatment then there is a further benefit of around £330,225. This is the difference between the costs of the 'no treatment' outcome of offending at the pre-treatment rate and the desistance outcome of no offending aggregated over the final eight years of the 20 year misuse career. This outcome is only achieved with a probability of less than one half, so the expected longer term benefits have to be discounted accordingly, giving a gross value of £195,149. Nevertheless the returns to successful completion are clearly substantial since this is achieved at a treatment cost of £11,019.

Appendix Table C.6.1 Harm reduction estimates and the returns from treatment

Year	Harm caused									
	No treat	Treatment outcome		Wtd av.	Short term value of treatment	Discounted value of treatment	Long-term value of treatment	Discounted value of abstain	Expected value of treatment	Discounted cost of treatment
		Recovery	No recovery							
1	55,127	43,087	43,087	43,087	12,040	11,633	0	0	11,633	2,899
2	55,127	43,087	43,087	43,087	12,040	11,239	0	0	11,239	2,801
3	55,127	43,087	43,087	43,087	12,040	10,859	0	0	10,859	2,706
4	55,127	43,087	43,087	43,087	12,040	10,492	0	0	10,492	2,614
5	55,127	0	55,127	29,932	0	0	55,127	46,415	21,214	0
6	55,127	0	55,127	29,932	0	0	55,127	44,846	20,496	0
7	55,127	0	55,127	29,932	0	0	55,127	43,329	19,803	0
8	55,127	0	55,127	29,932	0	0	55,127	41,864	19,133	0
9	55,127	0	55,127	29,932	0	0	55,127	40,448	18,486	0
10	55,127	0	55,127	29,932	0	0	55,127	39,081	17,861	0
11	55,127	0	55,127	29,932	0	0	55,127	37,759	17,257	0
12	55,127	0	55,127	29,932	0	0	55,127	36,482	16,674	0
<b>PV</b>						<b>44,224</b>		<b>330,225</b>	<b>195,149</b>	<b>11,019</b>

The application of these estimates to the findings from the differences in differences analysis of project impact is set out in section 7.5 which presents the cost-benefit results.

### Sensitivity analysis

The estimates of the value of treatment are critical to the estimates of the returns to DSCP just as they are to the more general issue of the returns to substantive drug treatment programmes. The existing evidence base as to the benefits of treatment, particularly over the longer term, contains a high degree of conjecture. It is essential, therefore, to consider the consequences of varying some of the assumptions and to check the robustness of findings to these changes.

The base case assumption is that those who complete a treatment journey successfully and go on to remain abstinent impose no further damage costs following treatment completion. This is unlikely to be the case in practice since this group of clients will take time to overcome the health and other problems (such as a high likelihood of a weak employment record) their misuse will have caused. In the absence of evidence as to the time profile of damage we explore the possibility that the annual damage costs during treatment decline exponentially following the completion of treatment.

A decay rate of 70% pa is sufficient to reduce damage from over £43,000 pa to less than a nominal £1 by the end of the eight year recovery period (which comprises years 12-20 of the default misuse career). Introducing this ‘adjustment phase’ into the recovery period reduces the Present Value of the saving from successful completion of treatment. But the joint effect of a high decay rate and the probability of continued recovery being less than 50% would be to reduce the expected value of treatment by the fairly modest amount of 2.8% (from £195,149 to 189,684).

Another important assumption of the base case is that the ‘no treatment’ pathway maintains a rate of damage which remains constant over the conjectured 20 year misuse career. Again, it is unlikely that damage will suddenly cease in year 20 and fall to zero overnight. More likely the rate of damage will fluctuate year by year, with a tendency to decline in the later years as drug users find ways of reducing consumption. It is also possible that the balance between harms of different types will change, with health costs tending to rise and offending costs being the source of possible reduction. In addition, the likelihood of remaining ‘outside the system’ while continuing to offend at the rate implicit in the DTORS damage estimates for 20 years cannot be very high.

Allowing the damage costs associated with no treatment to decline at 10% per annum reduces significantly the benefit from treatment since the counterfactual is now less costly and thus potential savings are smaller. On this assumption the Expected Value of treatment falls to £148,230 when the higher decay rate (as above) is retained.

## C7. Drug treatment budgets

Appendix Table C.7.1 Drug treatment budgets, activity and output 2004-05 to 2008-09

	Adult pooled treatment budget	Local funding	Total funding	Number of adults in effective treatment	Total treatment funding per adult in effective treatment
2004-05	£225m	£226m	£481m	134,000	£3,600
2005-06	£300m	£226m	£526m	145,000	£3,600
2006-07	£380m	£224m	£604m	164,000	£3,700
2007-08	£383m	£207m	£590m	183,000	£3,200
2008-09	£373m	£208m	£581m	195,000	£3,000

Source: Tackling problem drug use – National Audit Office 2010

The increase in the numbers in effective drug treatment has been rapid. The level of total funding reached a peak of £604m in 2006-07 and has since declined. The net result of increasing numbers and a falling total budget has been a fall in the spend per client.

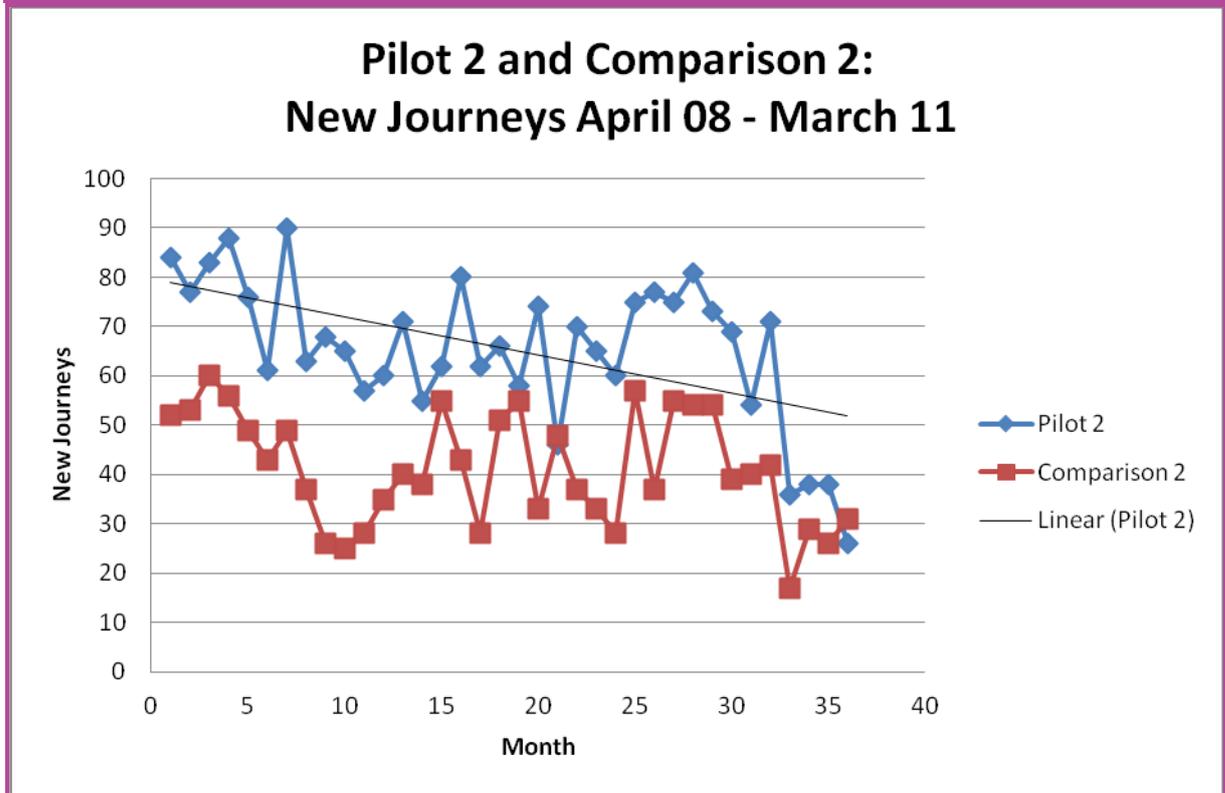
The pattern of spending of the APTB varies widely across DATs and treatment modalities. Table C7.2 shows the proportion of spending by principal budget head across the DSCPs.

Appendix Table C.7.2 Composition of APTB spending by pilot site

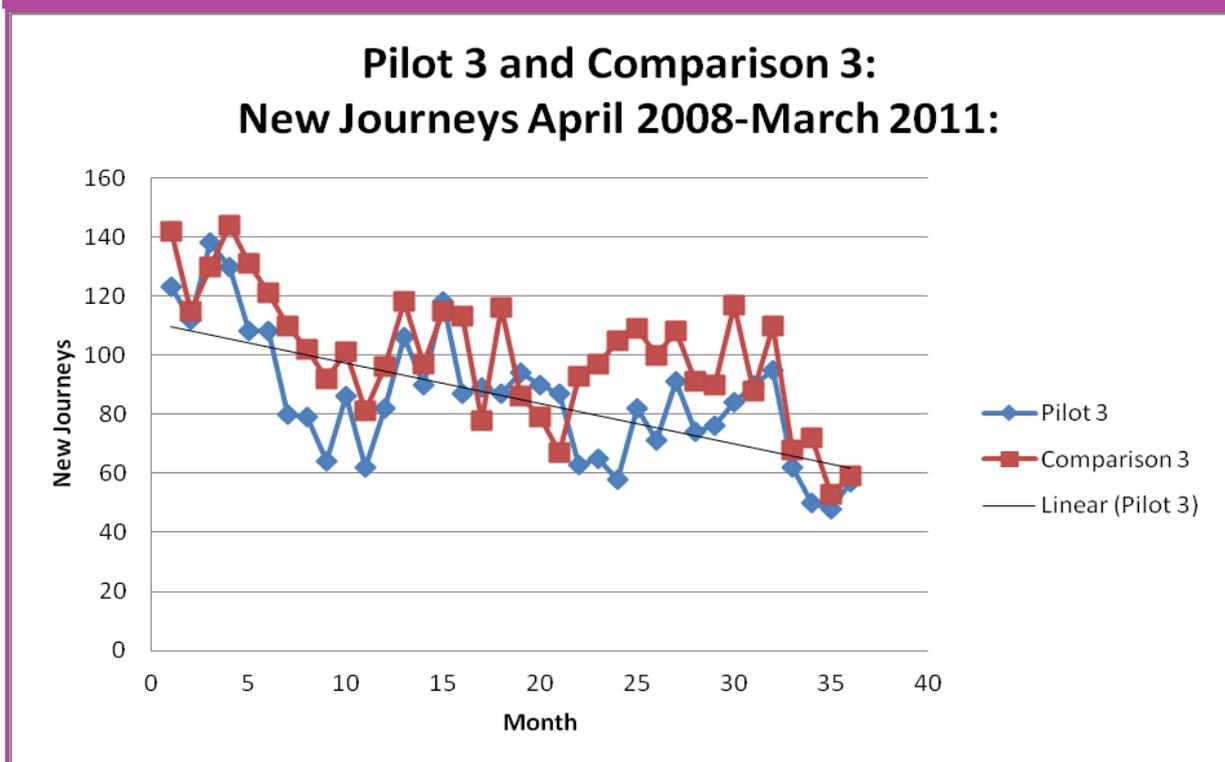
	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	All
<b>Commissioning System</b>	4.9%	4.0%	3.4%	2.8%	6.0%	1.4%	4.2%	3.6%
<b>Workforce Development</b>	0.1%	0.8%	5.8%	0.1%	1.1%	0.6%	0.3%	2.0%
<b>User Involvement</b>	1.0%	0.5%	0.9%	1.6%	1.3%	0.4%	0.1%	0.9%
<b>Carer Involvement</b>	0.7%	1.0%	1.4%	0.0%	1.2%	0.3%	0.6%	0.8%
<b>Harm Reduction Strategy</b>	5.7%	3.3%	10.2%	3.9%	6.0%	0.7%	4.8%	5.7%
<b>Non-drug treatment specific services</b>	3.5%	2.0%	5.4%	3.3%	7.6%	0.2%	8.4%	3.7%
<b>Open access drug treatment services</b>	7.9%	21.0%	4.9%	6.8%	5.7%	10.8%	9.4%	8.6%
<b>Structured community-based treatment services</b>	48.1%	45.8%	43.2%	30.6%	40.1%	69.7%	37.3%	46.6%
<b>Residential and inpatient drug treatment services</b>	15.3%	7.3%	6.0%	31.4%	7.3%	7.6%	1.9%	12.0%
<b>Drug Interventions Programme</b>	12.8%	14.1%	18.9%	19.5%	23.8%	8.4%	32.9%	16.0%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

## C8. New journeys started

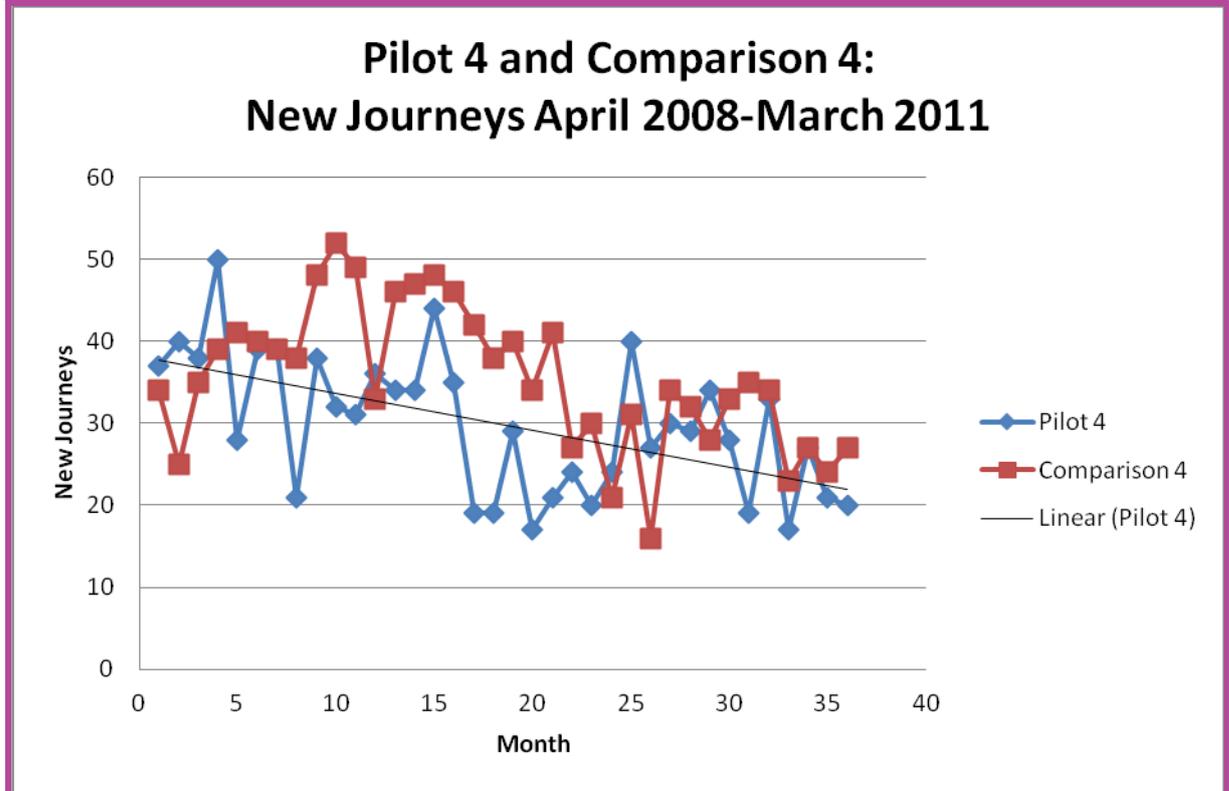
Appendix Figure C.8.1 New journeys: Pilot 2 plus comparison



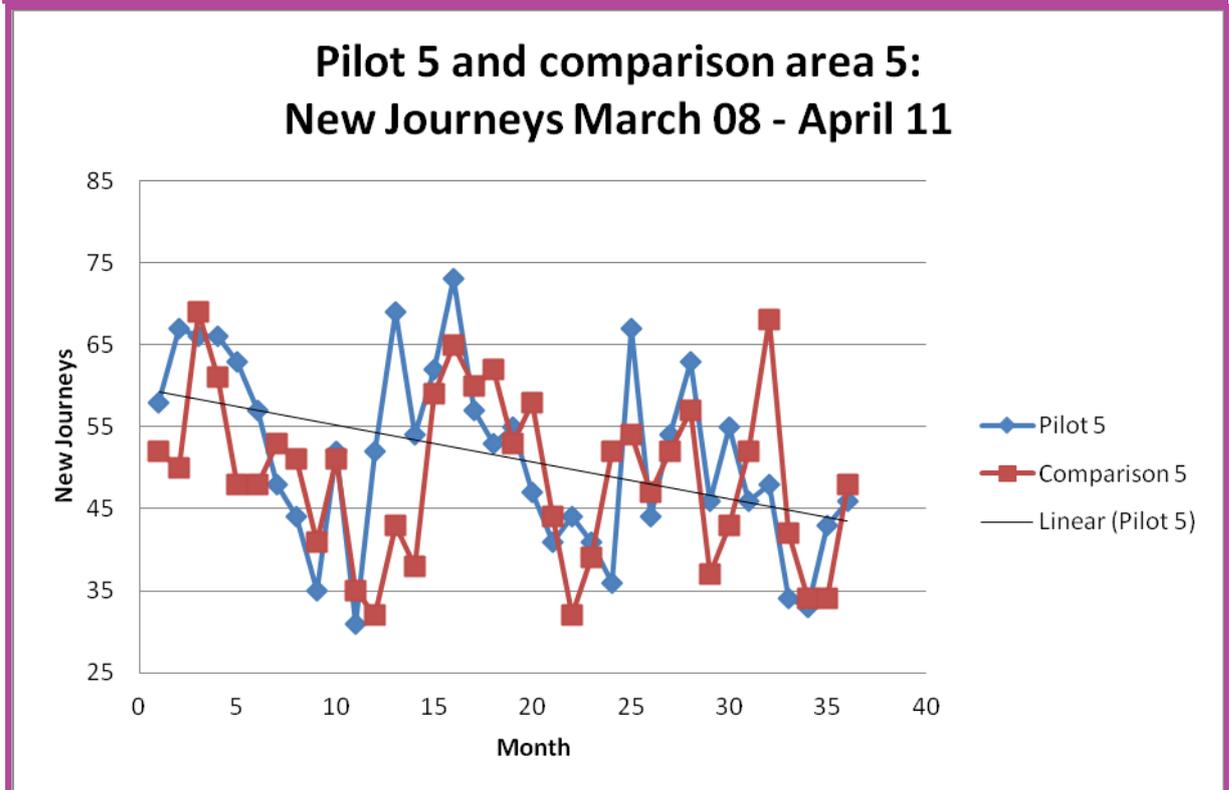
Appendix Figure C.8.2 New journeys: Pilot 3 plus comparison



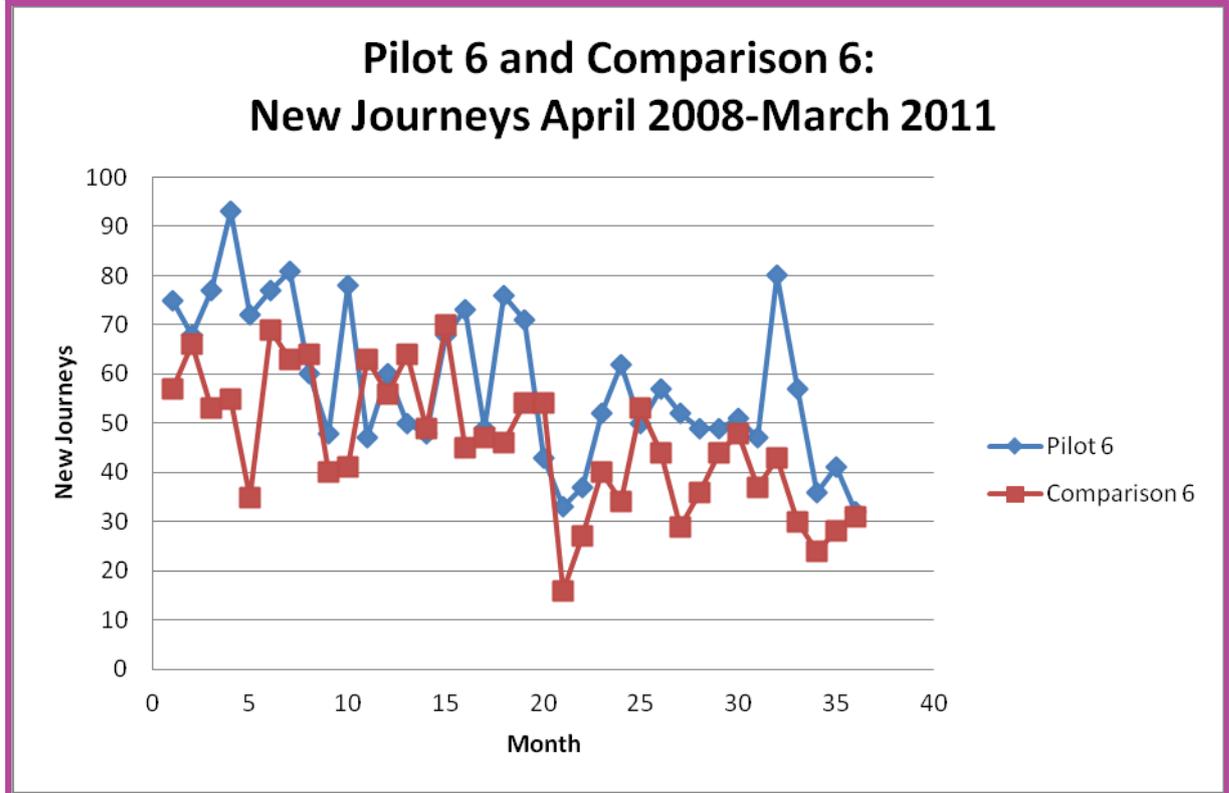
Appendix Figure C.8.3 New journeys: Pilot 4 plus comparison



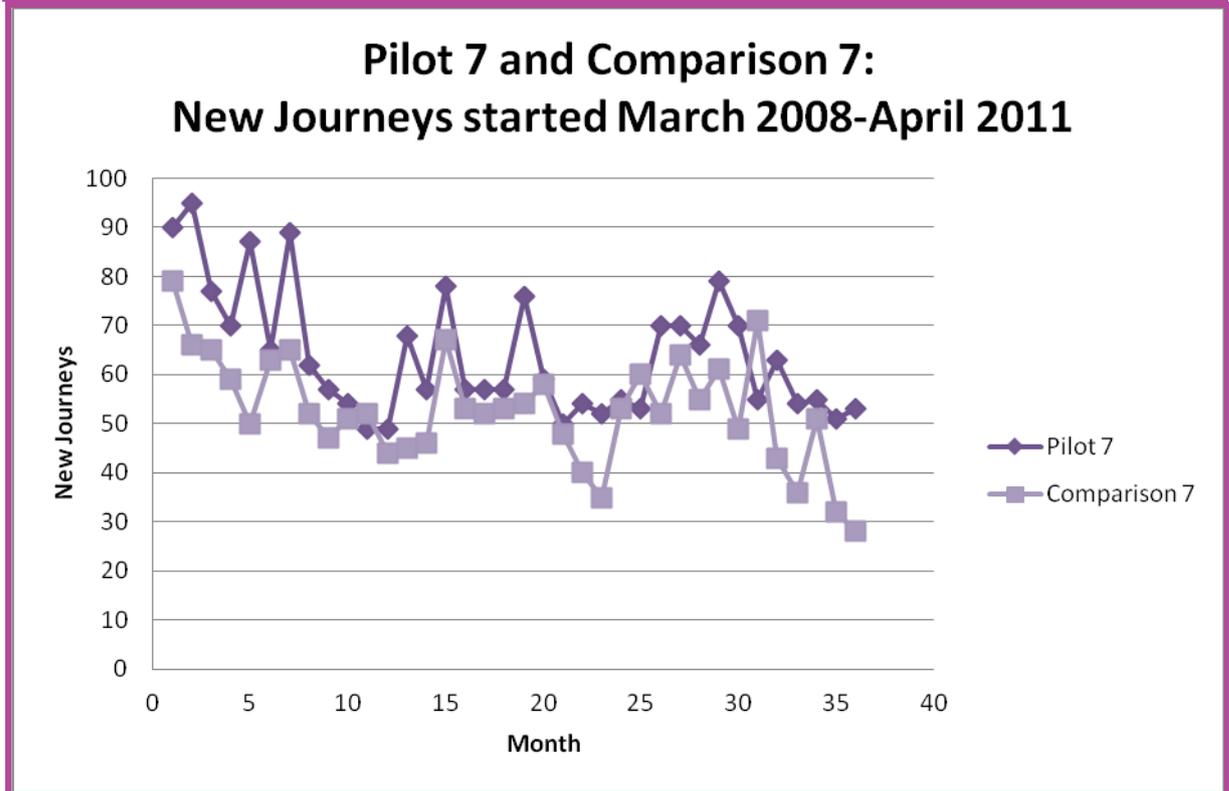
Appendix Figure C.8.4 New journeys: Pilot 5 plus comparison



Appendix Figure C.8.5 New journeys: Pilot 6 plus comparison



Appendix Figure C.8.6 New journeys: Pilot 7 plus comparison



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