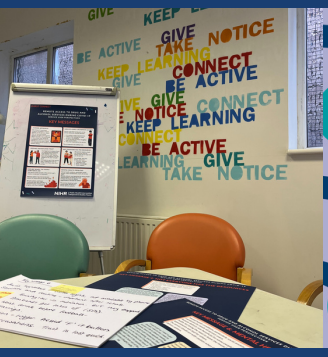
NIHR | Public Health Intervention Responsive Studies Teams

COVID-19 DRUG AND ALCOHOL SERVICE EVALUATION (DASE):

Research Briefing and Recommendations

September 2022



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RECOMMENDATIONS

These are the eight recommendations for drug and alcohol services based on the findings from the NIHR PHIRST funded evaluation research. Each recommendation is picked up on subsequent pages and the main findings that led the research team to make that recommendation are highlighted. If you want to know more about the methods used these are outlined at the end of the document.

Recommendation 1

A mixed or hybrid offer of both in-person and remote services should be available for both 1-2-1 and group support going forwards – who gets what needs to be flexible to service user circumstance, preference, and need. Supporting people at home or where they are is also needed for those who are most vulnerable.

Recommendation 2

The lead service provider organisation should formally review the technology, training, infrastructure, and resources required to deliver its desired future remote/mixed support offer.

Recommendation 3

The lead service provider organisation should explore ways in which service users' digital access and inclusion can be supported and consider developing a formal digital inclusion strategy/plan.

Recommendation 4

Assessment of the suitability/feasibility of remote delivery should be integrated into various stages of the lead organisation's initial assessment of service users. Clear criteria to assist staff in assessing the suitability/feasibility of remote delivery should be provided.

Recommendation 5

Homeworking should be offered as an option for staff, where feasible, with policy and guidance to ensure equitability. Office-based working space should also be provided.

Recommendation 6

The lead service provider organisation should review its range of drug and alcohol services and provide clear guidance for staff regarding whether each type of support can routinely be delivered remotely.

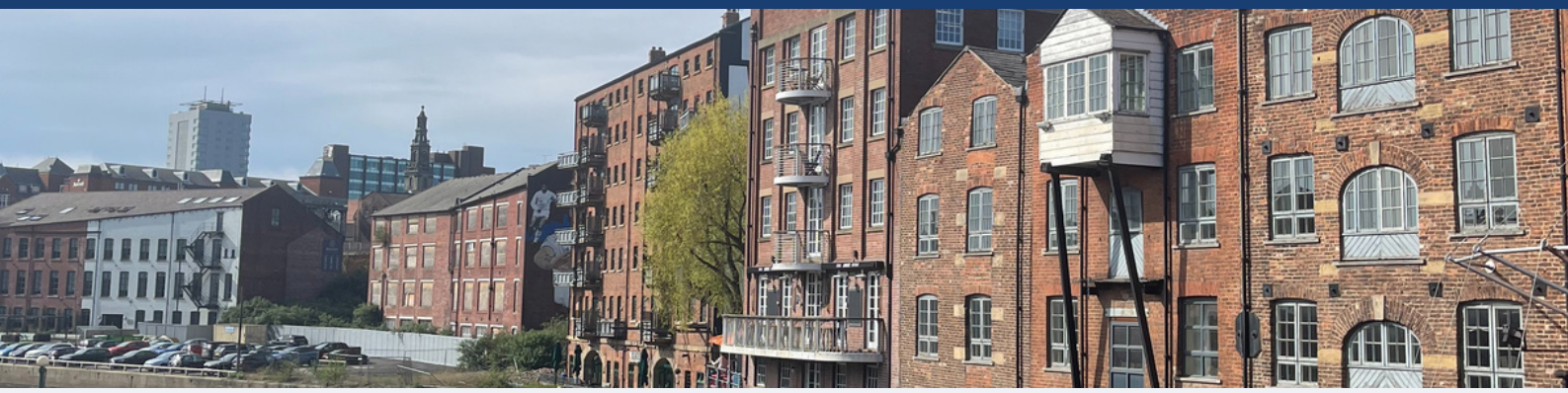
Recommendation 7

Face-to-face meetings between support workers and service users should be encouraged early in service users' engagement with services, or where specific risks or vulnerabilities have been identified.

Recommendation 8

The lead organisation should ensure that its monitoring and outcome data collection systems routinely capture the 'mode' (in-person or remote) of service delivery, to enable the effective ongoing assessment of engagement with, and outcomes of, both in-person and remote service delivery.

This evaluation is funded by the NIHR PHIRST (NIHR133206). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care



RECOMMENDATIONS: IN DETAIL

Recommendation 1

A mixed or hybrid offer of both in-person and remote services should be available for both 1-2-1 and group support going forwards – who gets what needs to be flexible to service user circumstance, preference, and need. Supporting people at home or where they are is also needed for those who are most vulnerable.

- Our systematic review of existing evaluations of remote interventions for alcohol and drug use found evidence that remote delivery can reduce drug and alcohol use. Due to the structure of services data, assessing effectiveness of services in terms of individual service user outcomes during versus pre-pandemic was not possible.

- Remote services offer flexibility and improved engagement opportunities for some service users. Although group work sessions decreased in number during the first year of the pandemic, the fact that they were online meant that people who engaged with them typically attended more group sessions per week than they had pre-pandemic. More people attended each online session as well.

- Remote delivery and remote working can mean that staff are able to work more efficiently. The service saw an 8% increase in numbers of service users between March 2019 and March 2021 and attendance at one-to-one appointments increased, whilst Did-Not-Attends (DNAs) and cancellations decreased. Decreased cancellation and higher attendances were maintained at one-year into the pandemic. This efficiency saving is unlikely to mean cost-savings since some aspects of virtual delivery can cost more and data suggest staff simply supported more people.

- Keeping face-to-face service options is still important as in-person support is preferred by some and important for good quality, safe care and support. Safeguarding and wellbeing checks require some in-person contact and in-person contact early on in a recovery journey can help to build trust and rapport between staff and service users. Some people may really need the social contact provided by in-person support and group work.

- Having the flexibility to offer both in-person and remote services adds a new dimension to tailored, trauma-informed and compassionate care. For example, offering telephone appointments to someone with severe social anxiety or with mobility problems.

- Some people have needs that mean that the service offer needs to go further – they need to be seen where they are. That may be at home or another suitable location in a place other than a service 'hub'. This might include young adults, who the data show reported poorest psychological wellbeing in the first year of the pandemic. It is also likely to include those with a disability or long-term condition and people living in the greatest deprivation, particularly in the current cost-of-living crisis.

- Engaging with services remotely gave some service users more autonomy around their own recovery and this increased their satisfaction with care and further supported their recovery.

Recommendation 2

The lead service provider organisation should formally review the technology, training, infrastructure, and resources required to deliver its desired future remote/mixed support offer.

- Staff highlighted the need for additional technological resource to enable them to work effectively remotely and deliver remote services.

- Space within hub buildings may need to be reconfigured so that staff can hold private conversations with service users including when delivering remote support.

- Access to Wi-Fi and digital devices, and the ability to use the technology needed for remote services, are barriers to remote services for many service users.

- Some service users need to travel a significant distance to attend a meeting in a 'hub' building.

- Allowing home working may help organisations to manage demand for building and parking space.

Recommendation 3

The lead service provider organisation should explore ways in which service users' digital access and inclusion can be supported and consider developing a formal digital inclusion strategy/plan.

- Access to Wi-Fi and digital devices, and the ability to use the technology needed for remote services, are barriers to remote services for many service users.
- The most 'vulnerable' service users may be among those least able to access remote services because of digital exclusion.
- Staff have developed informal ways of assisting service users in accessing remote support, and these could be built upon.
- During the pandemic, partner organisations were able to provide some service users with digital devices enabling them to access remote support.

Recommendation 4

Assessment of the suitability/feasibility of remote delivery should be integrated into various stages of the lead organisation's initial assessment of service users. Clear criteria to assist staff in assessing the suitability/feasibility of remote delivery should be provided.

- Each service user's experience/circumstances are unique and remote engagement in treatment may be unsuitable for some.
- The mental health needs of each person should be considered in deciding the type of support that is right for them. Remote delivery can be helpful for someone with severe social anxiety for example, but some people need in-person contact to support mental wellbeing.
- Some service users would prefer to routinely access services remotely and knowledge of this may allow service providers to match service users more effectively with the most suitable support offer.
- Attention needs to be paid to the physical, psychological, and social resources a service user has available to support engagement in treatment. Remote options may not be good for those with more limited resources to support their engagement.
- Staff commented that service users should be informed of the various support options available to them as part of the consultation process to assess the suitability of remote delivery.

Recommendation 5

Homeworking should be offered as an option for staff, where feasible, with clear guidance and policies in place. Opportunities for office-based working should also be provided.

- Staff described the efficiency and convenience of home and remote working (e.g. time saved by not needing to travel to/from work and between meetings).
- Staff highlighted perceived increases in personal work productivity because of homeworking allowing greater focus and attention on tasks.
- Staff described a greater ability to engage in multiagency and cross team meetings through use of video conferencing.
- Staff greatly valued being trusted to work from home during the pandemic.
- Office-based working also provides benefits for staff and service users (e.g., team working, information-sharing, signposting, team cohesion, and staff peer support).
- The complex and sensitive nature of drug and alcohol support means that regular, face-to-face contact with colleagues is often beneficial.
- Allowing home working may help organisations to manage demand for building and parking space.

Recommendation 6

The lead service provider organisation should review its range of drug and alcohol services and provide clear guidance for staff regarding whether each type of support can routinely be delivered remotely.

- Some components of drug and alcohol service delivery are particularly difficult to deliver remotely for logistical reasons and because of the varied needs/circumstances of service users (e.g., clinical assessments and comprehensive assessments).
- Some components of service delivery simply cannot be delivered remotely and therefore must remain face-to-face (e.g., tests for blood borne viruses).
- Routine Recovery Coordinator/Support Worker intervention work, group support sessions, and routine meetings with prescribers, are among the types of support better suited to remote delivery where appropriate for the service user.

- Remotely supporting service users can be difficult because of the challenge of accurately assessing service users (e.g., lack of visual cues/sensory information). Staff can be reliant on service users' honesty about their circumstances, substance use, and emotional and physical wellbeing. Safeguarding and wellbeing assessment typically requires at least some in-person contact.

Recommendation 7

Face-to-face meetings between support workers and service users should be encouraged early in service users' engagement with services, or where specific risks or vulnerabilities have been identified.

- Face-to-face meetings can be important for building trust, rapport, and the development of the therapeutic alliance.

- Remotely supporting service users can be difficult because of the challenge of accurately assessing them (e.g., lack of visual cues/sensory information). Staff can be reliant on service users' honesty about their circumstances, substance use, and emotional and physical wellbeing. Safeguarding and wellbeing assessment typically requires at least some in-person contact.

- It is easier for service users to deceive or mislead those delivering support when support is remotely delivered.

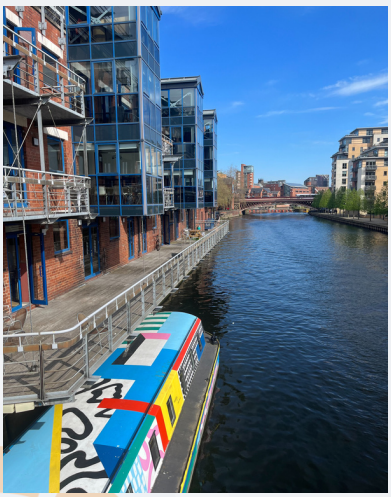
- A face-to-face meeting early in a service users' engagement provides a useful opportunity to assess the suitability of remote delivery to the service user's needs and circumstances.

Recommendation 8

The lead organisation should ensure that its monitoring and outcome data collection systems routinely capture the 'mode' (in-person or remote) of service delivery, to enable the effective ongoing assessment of engagement with, and outcomes of, both in-person and remote service delivery.

- Our discussions with service staff within the lead organisation suggest that mode of delivery was not routinely captured for all service user engagements with drug and alcohol support services in the first year of the pandemic.

- In a pre-pandemic world capturing this data was unnecessary but including it now and going forward would support future robust evaluation (within services or by external evaluators) of remote delivery of drug and alcohol services.



METHODOLOGY: HOW DID WE DO THIS WORK?

The evaluation was made up of five 'workstreams' which are described below.

1 Workstream 1: Aimed to identify and assess current published evidence about effectiveness of remotely delivered drug and alcohol support interventions.

We searched four databases of published studies with search terms related to drug and/or alcohol use interventions for adults. We then read through potential studies to make sure they were suitable, giving us a final list of included studies. With the final studies, we did the following things:

- Rated the quality of the studies
- Rated how well they improved alcohol and/or drug use
- Analysed the 'behaviour change techniques' used in the interventions that helped reduce substance use versus those that did not

2 Workstream 2: Aimed to explore staff experiences of the changes that occurred and their future preferences for service delivery.

The Leeds service provider organisations helped to publicise the evaluation among their staff teams. Staff members were invited to register to take part in the evaluation and 47 staff members registered and consented to take part. They were then invited to participate in one or more of the following data collection methods: a digital, online timeline where staff could give details of how services had changed and what their experienced of those changes had been; an online, videoconference focus group discussion; an online, one-to-one in-depth interview.

In total, 19 people completed a timeline, 17 took part in a focus group, and 18 took part in an in-depth interview.

3 Workstream 3: Aimed to explore service user experiences, the relative pros and cons for them and their preferences for the future of services.

With support from services based in Leeds, more than 100 service users volunteered to be contacted about their experiences. From this pool of potential participants, we invited and successfully recruited 17 individuals to have an in-depth interview by telephone or videoconference. Seven people took part in a videoconference focus group and eight individuals engaged with us in a text message or email-based interview.

In addition, staff who work with sex workers in Leeds were supported via two workshops to collect data from their service users during the normal course of their work with them. They asked women about their experiences during the pandemic, and what they wanted from services in the future. Staff then created a total of seven 'vignettes' of sex workers' experiences, which were included in the data analysis.

4 Workstream 4: Aimed to assess how outcomes for service users during the COVID-19 pandemic compare with pre-COVID outcomes; how service activity changed over the course of the pandemic; the resource and economic impact of changes in key activities; and the economic impact on service users of the service moving to remote delivery.

This workstream involved analysis of routinely collected data from the lead organisation for the period March 2019 to March 2021. It involved quantitative analysis of data that included service delivery, contacts with service users, service user characteristics and outcomes over time (including, outcomes such as substance use, quality of life, and psychological and physical wellbeing). It included an economic/cost evaluation of the different modes of service delivery (face-to-face and online). Data was drawn from service records (appointment booking system, capturing details of attendance), interviews with service users and staff (information on costs borne by them), and group meetings with Recovery coordinators and Group workers (to understand the resource and cost differences between F2F and virtual delivery of key activities).

5 Workstream 5: Aimed to synthesise workstream findings and co-produce recommendations for future service delivery

This workstream involved bringing together findings from workstreams 1 to 4, to generate recommendations for how the design of drug and alcohol services in Leeds might be optimised in future, drawing on lessons learnt during COVID-19. It also involved working in partnership with multiple stakeholders to develop ways of widely communicating evaluation findings to a range of interested parties.

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