An Assessment of the Contribution of Selected Voluntary Sector Providers to the Treatment of Substance Misuse

A. Introduction and Background

Introduction

Following the elections for the National Assembly for Wales (NAW) in May 2003, the incoming Welsh Assembly Government created a new ministerial portfolio with responsibilities for social justice and regeneration. Policy in respect of substance misuse became part of that portfolio and a policy review was determined upon. One part of that review was to be a study of the contribution to treatment made by selected voluntary sector providers. Those selected were organisations in receipt of monies under Section 64 of the 1968 Health Services and Public Health Act or monies from the Drug and Alcohol Treatment Fund formerly disbursed by the Drug and Alcohol Advisory Teams (DAATs) at a health authority level, working through Local Action Teams (LATs) at a local authority level. With the abolition of health authorities in March 2003 substance misuse became the responsibility of Community Safety Partnerships (CSPs) working through Substance Misuse Action Teams (SMATs) relating to the framework of the local Health, Social Care and Well Being Strategy. Substance Misuse Advisory Regional Teams (SMARTs) have been established by the Assembly for each area covered by the former DAATs.

On 29th September 2003, the Welsh assembly Government issued an invitation to tender for the study to organisations judged able to undertake it. The Welsh Institute for Health and Social Care (WIHSC) through the Commercial Services arm of the University of Glamorgan, supplied a tender which, after discussion with government officials, was revised and accepted on 2rd December 2003. The study commenced on the 3rd December 2003. The results of the study were intended to inform policy especially in respect of expenditure in the financial year 2004/5 and thus its findings were needed by late March 2004. An outline of emerging findings was provided earlier on March 12th to aid on going policy discussion.

Although the report was commissioned on the basis of consultancy, the client indicated that it would be received by the Advisory Panel on Substance Misuse[1] (APoSM) and might perhaps be issued more widely. WIHSC has written the report therefore on the basis that it might be circulated widely to a broad readership.

WIHSC would wish to thank all who have contributed to this study, especially the staff and trustees of the voluntary bodies visited, staff engaged in the commissioning of services related to substance misuse, the Chair and members of APoSM and staff of the Welsh Assembly Government.

[1] APoSM is an advisory body comprising individuals with knowledge of substance misuse from a range of statutory agencies, academia and the independent sector available to assist the National Assembly for Wales.

Background

The treatment of people experiencing substance misuse is delivered in Wales by a combination of service providers operating in the statutory and independent sector.

The former include hospital and community- based services offered by medical nursing and other staff, for example the prescription of medication and the supply of items such as needles to increase the safe use of substances, and staff employed by local government, including social services staff to provide assessment, counselling and other services.

The latter comprises predominantly organisations operating solely as charities or as charities/not- for- profit companies and about 30 such bodies active in Wales have been identified. The sector is marked by a high degree of diversity, especially given the maturity and size of providers and their different aims and values. This sector has traditionally received limited resources and it has developed, in part, in response to perceived gaps or shortcomings in statutory sector provision. It is generally well organised, operating to standards of governance that are similar in many respects to those of the statutory sector.

Funding streams for such bodies also display considerable variety with money coming from a range of charitable and statutory bodies. For the latter, funds come from three levels – England and Wales (e.g. Home Office), Wales, and local authority. Health, social services, probation, prison, and youth offending teams are amongst the main statutory funding agencies.

The commissioning process has undergone considerable change in recent years and in particular has been affected by the replacement of health authorities with LHBs and the inclusion of DAAT work into CSPs. CSPs are still coming to terms with their role and many face difficult challenges. First is the need to absorb staff new to the organisation or to the field of substance misuse; second the need to blend together the different skills, values and perspectives of the different agencies now combined within the CSP; third the complex task of creating a comprehensive and coherent pattern of local provision from multiple funding sources. It will be noted that some difficulty has been experienced in obtaining full input to the study from commissioners across Wales and this is no doubt due in part to these recent changes.

B. Terms of Reference

Remit

There were six aims of the study designed to aid learning about the treatment services offered by voluntary sector organisations.

The six aims relating to treatment services were "to ascertain:

- The nature and the extent of the services available
- Whether or not there is a duplication of services
- (The extent of) integration and co-ordination of services (both intra and inter agency)
- Service quality and effectiveness
- How effectiveness is measured, especially concerning outcomes
- Value for money."

Findings in relation to these are set out in Section D and lessons which might inform similar studies in the future are given in Section E. Conclusions are reported in Section F.

Although not strictly required by the terms of reference WIHSC has made certain recommendations that arise from the evidence gathered and these are given in Section G.

The study was confined to 18 providers, specified by the client, who were in receipt of specific NAW funds relating to substance misuse. This contrasts with a total of 27 voluntary sector providers operating in this field within Wales discovered and described in a recent study[2] plus a small number of other organisations discovered during the course of this study.

Project Management

The study was guided by a Project Board drawn from members of the Advisory Panel on Substance Misuse (APoSM). The project manager, representing the client, was Philip Guy of the Substance Misuse Branch, WAG. The project was required to adopt a project management approach based upon the Prince 2 methodology[3] but modified to reflect the short duration and relative simplicity of the study.

C. Methods

The study topic involved two groups of actors.

First were selected voluntary sector treatment providers known to, and identified by, the client numbering 18 in total, of which 16 were to be surveyed by both questionnaire and interview, and 2 by questionnaire only.

Second were up to 22 commissioners of services related to the treatment of substance misuse. The purpose of these interviews was to clarify the commissioning process, and assess its impact upon the six aims of the study. An initial point of contact for commissioners was identified by the client through the Community Safety Partnerships; however it was recognised that the arrangements for commissioning were less clear as a result of recent organisational changes and varied in detail from locality to locality. In

[2] Edwards L and Mason P, *Wales Substance Misuse Review 2002; Final Report,* Welsh Assembly Government February 2003

[3] Bentley C. PRINCE 2, A Practical Handbook, Butterworth – Heinemann, Oxford 2000

the early part of the study WIHSC sought to clarify the arrangements operating in each part of Wales.

For both groups a similar two- stage approach was adopted to the gathering of data. After the client had alerted both commissioners and providers, stage one commenced with data being sought by questionnaires prepared separately for provider and commissioner bodies. Questionnaires were forwarded to contact points identified in each provider or commissioner organisation and were accompanied by a separate letter which again set out the background to the study and its nature. The questionnaire to providers was forwarded by post on 9th December with an offer to forward electronic copies if these were useful. The version to all commissioners, for whom complete email addresses were available, was sent out electronically on 9th December and a paper version posted the next day. A covering letter to commissioners explained the reason for the study and the origin of the contact point used. It asked, if the recipient was not the person best placed to complete the questionnaire, that the recipient forward the documentation to a more appropriate colleague and use a supplied notification slip to advise WIHSC of the person to whom the documents had been passed.

Copies of the covering letters and questionnaires used are shown in Appendix 1a and 1b.

Stage 1 occurred between December 3rd 2003 and January 16th 2004 by when questionnaires were to be returned. Mindful of the tight timescales implied in the invitation to tender WIHSC part drafted "at risk" two questionnaires prior to the contract being awarded. When the contract was confirmed these were refined. The short time-scales for completing the study required that questionnaires be issued before Christmas, but part preparation allowed some limited piloting of these tools to be undertaken before they were completed and issued.

The questionnaire used for the voluntary sector was tested in two ways. It was discussed with a voluntary sector provider not intended to be part of the study and was judged to be understandable and well targeted. Minor suggestions were made regarding phraseology which were adopted. It was also discussed with the Chair of APoSM who considered it to be acceptable. The questionnaire for commissioners was agreed with the Chair of APoSM.

The questionnaires were designed to balance the need to:

- be capable of completion in the short time available between the issue date of 9th December 2003, and the latest return date possible, 16th January 2004, recognising that public holidays over Christmas and the New Year would mean that key actors would be unavailable, with
- be sufficiently comprehensive to ensure that the data gained would inform the subsequent interviews, and provide data relevant to the terms of reference.

Stage 2 consisted of a series of semi-structured interviews with key individuals from both providers and commissioners. These were to be informed by the data gathered by questionnaire which allowed key aspects of the service to be pursued in greater depth.

Stage 2 commenced on 19th January 2004 and the results recorded in written form using prepared documents. Copies of the interview formats used are given in Appendix 2a and 2b. The number of interviewees ranged from one to seven at the discretion of the organization being interviewed. With two exceptions, two interviewers conducted interviews with providers; those with commissioners were conducted by one interviewer and again recorded on paper. The difference in approach was explained by the degree of complexity and difference expected between different providers (in contrast to the greater uniformity of commissioners), the concentration in the terms of reference upon provider organisations, and the limited time-scales and interview resources allowed for in the project. Difficulties were experienced in confirming dates for meetings with commissioners and as late as February 20th dates had still not been agreed with eight of the twenty- two commissioners. A schedule of those interviewed in both provider and commissioner organisations is given in Appendix 3.

To maximise contributions, all interviewed were assured that findings would not be attributed to particular individuals or organisations without prior agreement; further it was stressed that the study was not designed to compare different providers or commissioners or to rank them in any way. Rather the study would use the data gathered to address the generic themes set out in the terms of reference.

D. Findings

Co-operation

Co-operation from Providers

Questionnaires from the 16 providers for whom interviews were considered appropriate were with three exceptions returned by the due date, often accompanied by detailed documentation adding to the information sought. Only one provider failed to return a questionnaire, two returned data some time after the due date, but prior to the interview. The majority of providers supplied data that the study team judged to be relevant and comprehensive. That from three providers was rather brief, whilst that from five was judged to be especially well presented and comprehensive.

Only one of the two organisations to whom questionnaires were sent and for whom interviews were not intended responded to the questionnaire.

Several providers stated that this was the third survey of their work that had been undertaken by the Assembly in a short space of time and commented that it was not immediately clear to them that the data now sought was much different from that only recently supplied. Particular reference was made to the survey by Lucy Edwards and Peter Mason referred to earlier which gathered data on 60 voluntary sector providers across Wales including all but 2 of those surveyed in this study. In retrospect, it might have been useful for those invited to bid for conducting the study to have received this report as part of tender process so that the study design could have taken into account that which was already known.

Voluntary sector providers also enquired whether similar scrutiny of statutory providers was being undertaken.

In all cases the study team were hospitably welcomed by providers who were invariably open about their work, sharing both their strengths and weaknesses. It is clear that they took the study process seriously and, in almost every case, did their best to supply the study team with the information sought.

At the conclusion of many interviews, providers indicated that they had found the discussion useful to them in helping them to think further about how best to deal with challenges faced and in prompting ideas upon which they could build.

Co-operation from Commissioners

Information from commissioners was not so promptly offered. By the due date only three questionnaires had been received; further it was clear that the lines of communication within the commissioning function as a whole were fragile. Difficulties were experienced in a number of CSPs in discovering where the request for data had been directed, and in only one case did the initial contact point inform WIHSC that they had forwarded the enquiry to another person. By the 15th March when the study team was no longer able to accept documents, questionnaires had been returned on behalf of 14 CSPs.

Different CSPs were at different stages of maturity in the development of their commissioning processes. In a number of cases, the staff involved were relatively new to the commissioning of substance misuse services and were not always clear about the other agencies involved. Several commented that they were operating under extreme pressure of work, substance misuse was only a small part of their work and the study could not be a high priority. In three cases, commissioners initially sought to refer the request for data to their local voluntary sector provider, for them to supply the answers.

The heterogeneity of voluntary sector providers

The 16 providers interviewed varied considerably in their aims, age, size, organisational structure and services offered. Further, different providers saw their **purpose,** as distinct from their services, in different ways. The study team paid particular attention to obtaining a statement from providers that described their aims/purpose in their own terms.

Aims

The following examples show the range of aims and values to which different providers were wedded.

"We provide residential rehabilitation to re-integrate clients into communities as worthwhile individuals with sustainable sobriety"

We aim to provide quick treatment so that people can be stabilised and can move forward so that they look better, feel better and get access to education and employment"

“Our aim is for the client to gain control (of the addiction) and make positive changes”.

“Our aim is to achieve a reduction in the amount of harm done by substance misuse and to support all who suffer from addition".
“We are about reducing drug and alcohol related harm based on clients choice re treatment; we promote safe and sensible use, or non use, of alcohol and non use of illicit substances”.

“We aim to intervene to break the cycle of addiction, taking people as they are and working with them”.

“We exist to ensure that drug users and ex-users fulfil their potential, and to minimise the damage they do to themselves and to others; we prioritise those at risk of death, disease and incarceration”.

“to provide specialist services to substance misusers and their families, in order to minimize harm as clients see it”.

“We aim to provide confidential support and information to families and friends of substance misusers”.

“We aim to enhance quality of life for users…to move people on from where they are-whether this is to reduce harm from substance misuse or to ensure that they have adequate housing”.

“Our aim is to provide a specialist service to substance misusers and their families. We minimize harm as our clients see it. If they want abstinence we will give them abstinence”.

“We are here to provide a service that purchasers wish to buy…. We also aim to be proactive not reactive…..if “success” is the aim it doesn’t follow just because people stop (misusing). Our aim is to ensure that people maximize their purpose”.

Size and maturity
Organisations ranged from one that was 30 years old, with 140 staff and a turnover of approximately £3.5m covering most aspects of drug and alcohol services, to a relatively new provider offering services to families of drug misusers operating with 2 staff and an income of approximately £76k. Organisational forms varied. Eight were both companies and charities, six were charities and two described themselves as services nested within wider organisations which had charitable status.

Service type
The heterogeneity of voluntary sector providers is also apparent when one considers the range of services they provide, and the predominant client group as described below:

		Substance misused		
		Primarily drugs	Primarily alcohol	Drugs and alcohol
Range of services	Comprehensive	2	2	7
	Narrow	3	1	1

NAW Funds and total income

The selection of providers to be studied was based upon those receiving funds from one of two National Assembly programmes, either Section 64 monies or Drug and Alcohol Treatment Fund money. As can be seen in Table 1, these specific funds represented different portions of each provider's income, ranging from 6% to 100% with the average percentage being 27. Total income to these organisations was in excess of £10.7m. There did not appear to be a common thread linking the application of NAW funds to each project. In some instances NAW funds were said to be for specific inputs, for example to pay for identified staff. In others it was a general contribution to core costs, but where this occurred it was without any clear indication as to whether or how this income was intended to impact upon the costs for services charged to local commissioners.

For most providers, the sources of funding were diverse. At the extreme one provider is currently managing over 60 different contracts. However, the typical provider relies upon between 5 and 8 income streams being often a mixture of charitable grants and contract income, often of different duration.

Apart from the two NAW funding sources specified above and CSP/LHB/Local Authority contracts, other funding sources include:

- Objective 1
- Lottery
- "Spot purchasing"
- Sure Start
- Compact Funds
- Comic Relief
- Supporting People
- Housing benefit
- Charitable Trusts
- Client payment

Harm reduction or abstinence as a goal

Different providers took different positions about the emphasis that they laid upon these two aspects. For all the providers, the key aim was to realize the client's own objectives. For some, however, this meant that they were only prepared to work with clients who were committed to achieving total abstinence, since this was the purpose of the service they provided. The majority was prepared to work with **all** clients to help achieve the clients' objectives (whatever they might be); this group would then refer clients on to more specialized services if appropriate. However, it is perhaps significant that at least two providers that initially took the view that abstinence was their main aim have, in recent years, modified this to accept that harm reduction should feature in their panoply of services.

Motivation of voluntary providers
A further distinction could be seen between:

- those services that sprang from, and still relied heavily for direction upon, those who themselves had suffered from the effects of substance misuse (experience-based provision),
- those which relied largely for service delivery and direction upon people without first hand experience of substance misuse, but who instead were trained in different aspects of counselling and therapy, coming perhaps from a nursing, social work or other professional background (profession-based provision).

The services offered by the former were more likely to be shaped by individuals drawing upon their own experiences to guide their working methods and the range of services offered whereas the latter would be likely to be guided by the particular techniques that professional staff supported. Some organizations had developed over many years from the former category to the latter. It was argued by some that services offered by individuals who had themselves overcome problems with addiction had a particular credibility with some of the harder-to-reach users; however, they tended to be smaller organizations, focusing on a narrower range of services.

In addition, a number of organisations had their origins in services initiated by concerned lay people.

A number of providers noted that it was now difficult to recruit trustees with sufficient skills and experience to refresh their management committees and that recruitment was mainly by personal contact.

Typology of organisation
In terms of the typology of organisations described by Mintzberg[4], all providers could be described as either ideological or charismatic in their approach, with several blending these two traits. A number of providers were originally founded by inspired individuals whose links with, or influence upon, those services remain strong.

The spectrum of services
A final typology concerned the services offered across a spectrum from prevention, informal befriending/drop in, formal assessment and onward referral processes, therapy processes aimed at gaining a commitment to securing harm reduction, treatment processes seeking abstinence (at varying levels of intervention/intensity), short term post-treatment support and long term post- treatment support.

[4] Mintzberg H., *Power in and around organisations*, Prentice Hall, 1983

A summary of 16 providers interviewed based on the above is given in Table 1 below which gives WIHSCs best assessment of each body's attributes.

Table 1. Summary of 16 providers: key characteristics[5]

Organ'n	Total Income £'000	% Income from		Main Sub-stance Type Drug/ Alcohol	Origin/values Lay Professional Past Experience of misuse	Service Range O=Other P=Prevention D=Drop In FA=Formal Assessment THR=Treatment Harm Reduction TA=Treatment Abstinence PTS=Post Treatment Support LTS=Long Term Support	Age in Wales in years	Organisational Status Company or Charity	Single or Multiple Sites
		All NAfW	Sect 64/ DATF						
A	£500k	94%	15%	D	Lay/Professional	D,FA, THR, PTS	20	Charity	S
B	£280k	49%	16%	D&A	Lay/Professional	FA ,TA	15	Company	S
C	£200k	65%	11%	D&A	Past Exp./Professional	P, D, FA, TA, PTS, LTS	11	Company	S
D	£380k	100%	100%	D	Professional	D ,FA, THR	1	Charity	S
E	£320k	77%	46%	A	Lay/Professional	FA, THR	20	Charity	S
F	£ 50k	100%	53%	D	Lay	O	5	Charity	S
G	£800k	95%	46%	A	Lay/Professional	FA, D, THR, LTS	39	Company	S
H	£340k	80%	12%	D	Past Exp./Prof.	P,D,THR,PTS,O	8	Charity	S
I	£274k	85%	6%	A	Lay/Professional	FA,TA,PTS	27	Charity	S
J	£138k	35%	12%	D	Past Experience	D, PTS	7	Charity	S
K	£557k	79%	36%	A&D	Lay/Professional	P,FA,THR,PTS	18	Charity	M
L	£550k	91%	27%	A&D	Lay/Professional	P,FA,THR,O	25	Company	M
M	£1.m	66%	13.5%	A&D	Lay/Past Exp.	P,D,FA,TA,THR,O, PTS	25	Company	M
N	£1.m	60%	15%	D&A	Lay/professional	P, FA,THA	17	Company	M
O	£850k	74%	12%	A&D	PastEx/professional	P,FA,THR	18	Company	M (outreach)
P	£3.5m	NK	10%	A&D	Lay/professional	P.D.FA,THR, TA PTS LYS	30	Company	M

Referral sources

A further feature was the range of sources of referral which in some cases exceeded 20. These included self referral which was the largest source for most providers, with probation and youth offending teams the next largest. (Residential services specifically were accessed almost exclusively through social workers). Other sources included family, G.P., hospital staff, social worker, housing bodies including tenant support, prison, school, other voluntary sector substance misuse treatment providers, and other voluntary bodies such as the YMCA and victim support. Referral sources were not known for three providers as the data was not kept.

[5] Col. 3, All NAfW, is an estimate of the %age of total funding coming from all National Assembly funding streams e.g. including LHBs, Local Authorities and other Assembly programmes.

Provider not interviewed

As noted earlier, data from two organisations was to be gathered using only a questionnaire. A completed questionnaire was received from only one of the two approached in this way. This organization is described briefly from the data supplied.

It operates in the field of specialised housing, and one of its projects offers a supportive, alcohol and drugs free housing environment to those who have committed to making positive changes in their lives. The aim is to help individuals develop personal resources, skills and strategies for mainstream living. In total 13 places are available; together with floating support, £136,000 is committed to this service. Funding streams include Supported Housing Revenue Grant, LHB, Housing Benefit and personal contributions. Section 64 money in the order of £34,000 provided 25% of the total.

It receives referrals from a number of sources including four of the providers described in Table 1 as well as other housing providers, health and social service bodies and the local probation service.

Skills available to the organization include housing, social work and counselling skills.

The extent of duplication

The study was asked to look at the extent of the duplication of services and findings are given below.

It might be thought that, in asking for this aspect to be assessed, there was a presumption that duplication was something to be avoided. The study team would caution against too ready an acceptance of this view. The term 'duplication' needs further definition before this can be assumed. For example, different agencies can provide superficially similar services within the same geographical area, but for such different client groups, or in such different ways, as in practice to be entirely dissimilar.

In fact, little duplication was found – using either a loose or more specific definition. It might however be that this is less a sign of efficient provision and more an indication of gaps in, and a limited range of, choice of service.

Between the providers studied

The study team found little evidence of duplication of services between the 16 providers studied. In the main each provider covered different geographical areas and, for a number, these geographical territories were largely discrete. Where several agencies covered the same part of Wales and appeared to be offering similar services to the same population, closer examination found that the precise mix differed. Services reflected different types of service or methods of engagement and were deliberately aimed at

different sectors of the community. For example, some duplication might be thought likely in one city where two voluntary sector providers exist. However, the history and emphasis of these is different. There is agreement upon respective "territory". One agency is skilled at managing those who have determined to control their misuse, whilst the other is specifically geared to make contact with, and help, those who have a more chaotic lifestyle, have not yet decided to cease using, and are the "more difficult to reach".

Most providers were prepared to work with **all** clients to help achieve the clients' objectives (whatever they might be) and, if appropriate, refer clients on to another agency. Agencies stressed the importance of having more than one route into substance misuse provision to accommodate the various needs of the client.

The study team looked closely at the descriptions of services offered by co-located agencies and in all cases the description of respective territories offered by the one agency corresponded closely with that offered by the other. The study team is satisfied that this reflects the reality of working on the ground rather than any pre-determined attempt to misrepresent arrangements to mask duplication.

Information gathered from commissioners supports the view that little planned duplication of service exists. That currently being commissioned is seen as relevant and complementary.

Yet it should not be assumed that because the range of services on offer is deemed appropriate, the existing range of providers should therefore be seen as immutable. In one location there was a preparedness by the commissioner interviewed at least to countenance the coming together of two providers but with the existing service range remaining. This view assumed that one organisation might do justice to the very different style of services presently offered by two. However, such an assumption that would need further consideration, for the study did not set out to assess whether large all-purpose providers were inherently more effective/efficient than specialist operators.

Between the providers studied and other voluntary sector providers

The study concentrated upon only 16 voluntary sector providers from about 30 who operate in this field, and upon the commissioning process. Information in respect of duplication between all voluntary sector providers therefore was derived via the 16 providers studied and from commissioners. The preliminary conclusion drawn is that, just as there is little duplication directly among the 16 studied, there is also little between the 60 voluntary sector providers in Wales. Most might be viewed as occupying a particular niche in the delivery of treatment that is defined either by geography, service range, or service philosophy, with little overlap.

There are, however, two caveats to this preliminary conclusion. First, evidence has not been taken from the remaining voluntary sector providers and it is possible that they might have a different view of the extent of duplication. It is understood that the work of Edwards and Mason referenced earlier could inform this consideration. Second, in a few

localities, there are voluntarily provided services – often recently created and funded outwith local funding sources- about which knowledge is scant and therefore it has not been possible to make any assessment of the extent to which these duplicate services are offered elsewhere. Most commissioners were aware of 'other' providers, and had attempted to bring them into the SMAT. However, some commissioners stated that they lacked powers to address duplication resulting from services being planned outside the SMAP or funded from sources outside the DATF. Moreover in some areas there are real concerns about action by the Welsh Assembly Government to commission services directly, about lack of consultation and whether the particular services complement or duplicate what is there already.

Between providers studied and statutory and other providers
The study derived data about these relationships from the 16 providers interviewed and from commissioners. The extent of duplication between the voluntary and statutory providers was not entirely clear. Some services, for example detoxification, methadone prescribing, and counselling services, were provided in both statutory and voluntary sectors. However, the style of those services, their ability to reach out to different user groups as a result of their image, and their different levels of accessibility, suggested that duplication did not, in the main, occur. Further, some services offered via the voluntary sector that already existed in the statutory sector appear to have been deliberately commissioned as both a quantitative addition to those offered by statutory agencies as well as being qualitatively different.

Gaps in service

Although not required by the terms of reference to consider gaps in service, this was considered to be a corollary of looking at duplication. This section therefore summarises **possible** gaps in provision, but clearly these would require verification from a study specifically designed to test this issue.

Three possible types of 'gaps' were revealed in the study:

- geographical gaps – parts of Wales or individual local authorities where the level of provision is significantly below what might be considered adequate, or below the norm for comparable areas;
- service gaps – where particular client groups are under-served; these might include demographic groups (such as ethnic minorities, older people, children, disabled or homeless people), or groups for whom particular services are lacking (e.g. 'wet' hostels, in patient beds, dual diagnosis, drop-in facilities, crisis intervention)
- 'adequacy' gaps – where a full range of services is apparently available, but in reality the supply is so constrained (in relation to demand) as to deprive people of an acceptable level of provision (e.g. excessive waiting times)

The extent of any such gaps clearly requires substantiation. However, most of the interviewees argued that gaps in provision were far more significant than any apparent 'duplication'. They further stated that the current pattern of provision was the result of an historical lack of investment (which had created gaps) rather than a response to need

(which might have caused duplication). Many commissioners suggested that additional funding is needed to provide scope for re-orientating current funding to address gaps.

The degree of co-ordination of services

Between voluntary sector bodies

Between voluntary sector providers operating in close geographical or service proximity there is often a good level of co-ordination of services for individual clients, with inter-agency referral frequently operating through well-established formal and informal agreements and with different service providers working hard to ensure that their services are complementary rather than competitive. Personal relationships between staff of different voluntary sector providers appear, on the whole, to be good.

This broad conclusion however is modified in three respects.

First, particular models of care appear to give rise to some controversy in respect of their general or particular applicability. Treatment approaches based on the Minnesota model have been highly praised by those using this approach who claim that, on the evidence, it is among the most effective of interventions. Equally, other providers who follow different methods, have expressed concerns about the perceived rigidity of this approach and there is some suggestion that such reservations, if not impeding cooperation, may affect the degree of cross referrals.

Second, the role of specific services in Wales, for example residential services do not command universal support among commissioners or other providers. Such services are tailored to a small, well-motivated client group such that they are unlikely to have many clients suitable for referral.

Third, in more strategic and developmental terms, there appeared to be a marked lack of cooperation between voluntary sector providers. Whilst concerns were expressed about sharing of commercially sensitive information, many providers recognized the potential benefit of closer cooperation, in such areas as

- sharing good practice – in all aspects of their work, from outreach and referral protocols, to particular therapeutic and administrative processes
- performance measurement – sharing experience and jointly developing useful and practical measures of performance
- benchmarking performance – using such measures to highlight more and less successful approaches to treatment
- cooperation in new service development
- informing the commissioning and policy areas – to ensure the maximum contribution of the voluntary sector.

In some areas voluntary sector providers are part of the SMAT or its constituent committees, including the commissioning sub-group, whilst in other areas the local council of voluntary services represents them.

One provider quoted links with other providers in the UK and Europe as part of its developmental agenda; most reported little contact with other voluntary sector providers – either locally or nationally – apart from contact about individual clients. They expressed considerable interest in the possibility of developing such networking and benchmarking opportunities, which could take a variety of forms, informal or formal.

Between statutory and voluntary sector providers

There are a number of examples where voluntary and statutory services work in mutual support; for example where a voluntary provider supports hospital-based midwifery services or specialist primary care prescribing services offered by the statutory sector.

Some areas of concern however have been found within the voluntary sector regarding their relationship with the statutory sector. Whilst the study has not been designed to test these concerns with the statutory providers involved, those quoted have been raised independently in a number of locations and are therefore reported here.

First, the links between voluntary service providers and statutory community drug teams have been criticised in several parts of Wales. Here the voluntary sector providers stated that the remit of the community teams is unclear, or is not consistently followed, or fails to deliver in an effective, timely or cost effective way. Further, voluntary sector providers stated that their own role and skills were neither well understood nor respected by the statutory sector. Attempts to improve links and to engage the statutory sector in understanding their work have not always been reciprocated, and some voluntary sector providers reported a distinct resistance from the statutory sector towards proposals for the re-configuration of local service provision. In some areas, however, relationships were good, and this successful experience might offer some useful lessons to those parts of Wales where relationships could be improved.

Second, specialist providers serving wide catchment areas experience some difficulty in relating to other treatment providers who might be expected to refer clients to them.

Service quality

Providers

Quality assurance processes

Discussions on quality have to take into account the mission and values that underpin the different voluntary sector providers. As noted earlier, these vary considerably.

Providers could be divided into three groups in respect of their approach to quality assurance processes:

a) those that were able to demonstrate good understanding and documentation relating to quality assurance processes, having a clear idea of the determinants of quality services and operating with good oversight of these processes, including up to Trustee or Board level;

b) those that had significant elements of quality assurance operating, but recognized that further development was necessary; and

c) those whose were able to show little by way of systems of quality assurance .

Whilst, given the limitations of the study, it is difficult to categorise providers with absolute precision, the study teams assessment would be that 6 providers were in category (a), 8 in (b), and 2 in (c). In general, the larger and older organizations – perhaps not surprisingly – had developed the most comprehensive and robust systems of quality assurance. However, there were some examples of older organizations which had only recently recognized the need to **assure** the quality of provision, rather than simply relying on personal or other ad hoc checks.

There was considerable agreement among providers in respect of the features that ensured quality services. These were:

- inculcating and regularly reinforcing a philosophy which ensured that clients were respected as individuals, and were enabled and empowered rather than made dependent
- the use of management tools to plan services and score added value (e.g. DANOS[6] and the Christo Inventory[7])
- ensuring that services are client led and exceed user expectations – and where appropriate clients returned to the agency if they needed further help
- providing timely and accessible services that were seamless and easy to use
- working from an appropriate environment, for example one that was domestic in scale, welcoming, uncluttered and clean
- using well trained and qualified people, whose skills were accredited where possible and regularly updated using a deliberate process
- ensuring a robust system of staff and volunteer supervision
- providing services which were evidence-based
- following written procedures to guide the delivery of interventions and the training of staff and volunteers.

Most providers also acknowledged the importance of actively seeking feedback from clients and using this to develop or change services. However, many also reported considerable difficulties in achieving this, given the circumstances of the majority of their clients, and their resistance to any system of 'token' client feedback or involvement.

Skill levels

In addition to formal processes of quality assurance, most providers recognized that the greatest contribution to ensuring a quality service come from using staff (or volunteers) that were skilled, well trained and supervised. Skill levels could be of two broad types, those relating to delivering treatment and those related to managing the organisation.

Overall, skill levels within voluntary providers were high, with many committed to maintaining and developing staff skills through a variety of in-house programmes. A small number built the costs and time needed for staff training into their budgets and working methods.

[6] Drug and Alcohol Occupational Standards, a tool to help deliver high quality services in this field created by eight national training organisations, government departments from the four countries of the UK and key voluntary bodies.

[7] A tool developed by Dr Christo to elicit care managers impressions of their clients quickly and reliably.

The treatment skills to be found in providers interviewed varied in line with the particular niche which each organization occupied in the panoply of services offered.

In a small number of providers, skills were derived from the past experience of ex- users of drugs or alcohol rather than being acquired through any formal learning process and these tended also to be light on other formally acquired organisational skills. Most providers however displayed an array of talents among both treatment staff and those involved with the management of the organisation.

For treatment staff formal learning processes were broadly of two kinds, first those set within the requirements of recognised professions such as medicine, nursing (RMN and RGN), psychology, teaching or social work, second those arranged by the individual provider as part of their own training programmes.

Counselling services in particular varied from provider to provider in terms of the experience available and the extent to which counsellors had recognized qualifications. A number referred to British Association for Counselling and Psychotherapy accredited counsellors and senior registered practitioners. Others quoted specific counselling skills such as motivational interviewing taught to diploma level, addictions counselling reality therapy and solution focussed brief therapy. Counselling skills at M.A. level were also present. Awarding bodies included the University of Kent, Shrewsbury College, Clouds House, University College North Wales, Swansea University College and Hazelden Institute.

One provider also had skills in psychotherapy with a member of staff registered with UKCP.

Some providers looked for NVQ awards for support care staff.

In respect of management, in addition to general degrees qualifications included MBA, Masters in Health Promotion, HNC Business Administration, and Accountancy Technicians qualifications.

One commissioner has developed a training organisation to address what it perceives as lack of capacity amongst providers of substance misuse services.

Residential services

Unlike other elements of provision, residential services fall within the remit of the Care Standards Inspectorate for Wales. As a result standards are set and monitored by an outside agency. However, the framework of regulation appears to be heavily geared towards residential and nursing homes where longer rather than shorter lengths of stay are expected, and where the care regimes differ greatly from those in place in care environments dealing with substance misuse. The present limit of 16 beds adopted in Wales was said to sit uneasily with the organizational patters preferred by providers, and was also different from the standards applied in England.

Commissioners

Commissioners responsible for Substance Misuse Action Plans have only recently submitted these to the Welsh Assembly Government for approval of the 2004-5 Drug and Alcohol Treatment Fund and other resources. It is early days for the commissioners to have developed detailed quality standards, particularly as the 2003-2004 financial year has been one of transition in which the programme pursued by the DAAT has been guaranteed. Each of the commissioners appears to have worked in isolation within a funding framework provided by the Community Safety Partnership and the policy framework of the Local Health, Social Care and Well Being Strategy to develop their Substance Misuse Action Plan. As a result specifications of expected quality standards vary considerably between commissioners. Some have developed "mission statements", but generally their conception of quality tends to focus on the following:

- conforming to requirements – timeliness, effectiveness, impact, delivering what is intended within a robust financial clinical corporate and user satisfaction framework
- appropriateness – services that meet the needs of clients and commissioners and delivered in ways such that clients want to access them
- accountability – good reporting systems to confirm activity and prudent financial management
- safety – ensuring that appropriate staff are recruited, trained and supervised
- effective partnership working – sharing good practices across the substance misuse sector.

On the whole, there is little evidence of a well-developed approach by commissioners to the specification of expected quality. Sections in standard contracts that purport to deal with quality are, on the whole, capable of improvement; presently some simply refer to the providers own quality standards, others have been taken from other services and have been applied to treatment providers dealing with substance misuse. For example a number of the quality specifications used to procure residential services are clearly an adaptation of paperwork used to commission long term care for the elderly. Although money has been set aside in some areas to audit quality, generally there is no infrastructure, resources or skills to carry out independent analysis of the service level agreements made with providers. Furthermore, without 'baseline' measures or a clear understanding of the impact they are trying to make, many commissioners are struggling to assess quality. Commissioners do not have the capacity presently to monitor quality (e.g. by checking standards against QuADS[8] and DANOS. Those seeking to improve quality assurance are looking to the newly established SMART teams, or to establish benchmarking clubs, in order to achieve this.

Some of the more 'specialised' commissioners – those with more narrowly defined client groups (such as Job Centre Plus or the Probation Service) – have been able to develop a somewhat more sophisticated approach to quality assurance in commissioning. In some cases, they have been able to define outputs more closely, and have standard

[8] Quality in Alcohol and Drugs services – a system for assuring service quality

requirements for assurance processes. The more 'generalist' commissioners - those such as CSPs and LHBs who commission for a wide variety of clients and needs – might usefully examine these requirements, and work together to standardize their own contractual arrangements.

Effectiveness of treatment and outcomes

The study set out to discover what processes were used to measure effectiveness and to review outcomes. The first is easier to achieve than the second.

Commissioner impact upon measuring effectiveness

Commissioners generally have not yet established what services are needed neither in quantitative or qualitative terms, nor in terms of inputs, processes, outputs or outcomes. Without this baseline it has not been possible to lead the process of determining which services are offered or which services are deemed to be effective either in their own defined terms or in respect of their place in a wider mosaic of services commissioned to make a coherent whole. For example, if the achievement of abstinence was a commissioner requirement this is capable of being measured, at least in the short term and, with some changes and with some difficulty, in the longer term. If the reduction of harm was seen to be the main aim of commissioned services then a clearer commissioner definition of harm than that seen in the study is necessary and, probably, possible. Harm here may be regarded as harm to the individual in terms of different facets of the quality, or quantity of life, harm to the individual's family, and harm to wider society. One provider, for example, suggested that a "menu" of measurable harms straddling these three aspects could be drawn up between all commissioners and providers in Wales and used to gauge the extent to which harm is being reduced; indeed it had already built a version of this approach into its own performance monitoring arrangements.

There is a difficult potential mismatch between commissioners who want specific outcomes – harm reduction, etc – and providers who are primarily concerned to meet what individual clients want. Therefore commissioning good assessment processes and measuring success at delivering the sorts of progress that the individual clients say they want may be one way forward.

The different types of service on offer lead to systems for measuring effectiveness being diverse. The more resilient systems were those designed to plot the impact of counselling and other direct forms of treatment; less clear were systems seeking to measure the impact of programmes aimed at prevention and making contact with the more vulnerable groups.

Not all of the data necessary to measure impact is capable of being generated by treatment service providers alone; some of this data is held by different statutory bodies – for example parts of the criminal justice system. Also, if data is to be generated by providers, the cost of its collection and interpretation should be reflected in the resources made available to those charged with its production. Only in one part of Wales has

evidence been seen that grants and contract payments recognise the costs of data gathering and reporting.

In order for effectiveness to be measured, there is a need for broad agreement to be reached between policy makers, commissioners and providers on the precise objectives that treatment services are meant to achieve. Comments by many providers and a number of commissioners suggest that there remains considerable room for an increase in mutual understanding in this respect. For example, the aims intended for treatment services appear to differ among those coming to the commissioning process from different perspectives such as health and the criminal justice system. Many providers and a number of commissioners referred to the recent emergence of a possible conflict in aims between those concerned with treating individuals to improve their health and well being, and those seeking to reduce the impact of substance misuse upon levels of crime. There are also different perceptions about the targets of harm reduction – whether the individual substance misusers, their family or the wider community – and whether the focus of attention should be more on alcohol (primarily because of its impact on the health and wellbeing of individuals, their families and the wider community) or on drugs (primarily because of its impact on criminality and the Home Office agenda).

Within this framework, commissioners state that their objectives are to achieve the 4 key themes of the National Strategy[9] including the following:

- to promote healthy lifestyles
- to improve the health of the population
- to improve the well-being of families, particularly children
- to reduce harm
- to ensure a range of diverse provision to enable user choice
- to deliver quality services equitably, accessibly and appropriately
- to reduce availability of drugs on the street
- to reduce criminality

The influence of commissioners upon the data collected by providers has two main impacts.

First most commissioners specify data that they wish to receive as part of their monitoring of the agreements they have, and clearly providers give priority to that data in order to meet the requirements of their funders. A useful approach to reporting on work done is to consider the extent to which essential inputs, processes, outputs and outcomes need to be captured in data form:

- *Inputs*, especially human resources, may be described not only by reference to numbers of whole time equivalents, but also by reference to skill type and level required. The development of standardised qualification will be helpful here

[9] WAG (2000): 'Tackling Substance Misuse in Wales: a partnership approach'. The 4 key themes are:
(1) Children, young people and adults
(2) Families and communities
(3) Treatment
(4) Availability

- *Processes* might be specified by reference to one therapeutic approach or programme rather than another and could also refer to the evidence valued by commissioners and leading them to seek such processes
- *Outputs* might be described in terms of the volume of actions that are expected over time, or the short-term impact on clients' circumstances and needs.
- *Outcomes* describe the expected impact of the combination of inputs, processes and outputs, usually measured over a longer period (perhaps several months or years after intervention).

Commissioners may be content to specify in detail only one or two of these four – for example describing required outcomes whilst leaving providers to determine inputs outputs and processes. Clearly outcomes are a particularly relevant measure insofar as effectiveness is concerned; however data currently sought by commissioners appears to concentrate mainly upon inputs and outputs. This approach is likely to continue for as long as the vision of the programme and its long term impact and outcomes is limited. Further, outcomes by their nature require time to assess and often require information to be collected by bodies other than treatment providers.

Second, most providers have stressed that the collection and analysis of data is a time consuming and expensive process for which funding is rarely specified. Further, since the creation of the National Assembly, demands for data have increased both from the centre and from a multiplicity of funders each looking for different data items. Commissioners could wield greater influence in standardising the range of data needed – in conjunction with providers - and then in investing in the data systems that providers should use.

Heterogeneity of providers and commissioners

On the provider side, the 16 agencies are different in their experience, maturity, and services offered. Further, on the commissioner side, the different bodies involved in commissioning across the piece – rather than those involved in just Section 64 or Drug and Alcohol Treatment fund monies – adopt different levels of sophistication in what they require of providers by way of reported measures. Several providers contrasted the relative sophistication of the Probation service and Job Centre plus as commissioners with that of health and local government commissioners and, more importantly, what they fund providers to collect and analyse by way of data. Third, there is a clear distinction between those services that operate on the basis of ensuring abstinence, and those that seek harm reducing behaviours.

The study found that all providers had a clear notion of their aims and many could articulate these, either immediately or once prompted, and describe how they sought to measure their progress in achieving these aims. It is important to note however that the aims the providers set for themselves were not necessarily those reflected precisely in commissioning documents; neither were there always good long term processes for measuring how well these aims were met over time, for often the extent to which aims had been met could only be assessed by agencies other than the provider because of the timescales or settings involved.

Provider measurements of effectiveness

In order to measure effectiveness, it is necessary for there to be clarity about the aims of the services offered. As noted earlier providers were pressed to summarise their aims as a precursor to discussing how far those aims were being achieved and some of these aims are further examined below.

Aims of organisations were described differently, but could broadly be included within the following categories:

- providing education and information in order to prevent substance misuse.
- making appropriate and effective contact with as many as possible of the client groups in greatest need
- ensuring that those referred were kept in contact with the treatment agency
- achieving a measured extent of harm reduction, against objectives defined together with the client at the outset of the process, and subsequently
- achieving total abstinence for those selecting this as a long term goal
- working with the client to address other aspects of their lives which tend to reinforce misuse of substances (e.g. housing, relationships, child protection, income and social exclusion)
- referring clients to other agencies as appropriate
- ensuring clients were re-integrated back into communities and to work
- ensuring clients felt, and were, valued for themselves as a pre-requisite for effective intervention to break the cycle of addiction
- ensuring better awareness amongst the wider community so as to reduce the stigma of substance misuse.

Judged in these terms, providers offered measures of differing levels of robustness for each of the above.

In terms of those services aimed as prevention, as in many other areas, data regarding effectiveness was difficult to find.

Information about the extent and regularity of contact of clients with agencies appeared to be adequate.

Data regarding the levels of abstinence predicted to be achieved, and actually achieved, by following particular programmes were available from most providers. However there

were different claims offered about the efficacy of different programmes. For example, in terms of treatment aimed at abstinence, different rates were quoted for those completing counselling and other programmes as were rates given for those achieving abstinence and maintaining it for a period of time after treatment. Clearly any measures of effectiveness such as these need to bear in mind two matters. First, providers usually have no means of keeping in touch with clients over a long period of time and thus are not in a position to know how well past clients are faring. Second, completion rates for courses of treatment will be heavily shaped by the circumstances of the clients served, the quality of the assessment processes used to accept clients onto programmes, and the thresholds for acceptance on to programmes. If strict criteria are used so that only those most likely to succeed are accepted then success rates will be high. If a more liberal approach is adopted so that clients are accepted who "may well fail but deserve a chance" then completion rates will be lower.

Data about levels of harm reduction were documented in most providers and in four were particularly well developed. However, these data applied at the individual client level and for the time that the client was in contact with the agency. There were difficulties in summing the experience of individuals to produce aggregate data and difficulties in measuring on going success after contact had been lost. In this respect there may be a role for commissioners in developing community- based approaches to data gathering.

In terms of seeking to measure levels of integration of clients back into communities, this was still at an early stage, with that work which was in hand assessing integration from the perspective of the client. No measurement of the views of the communities involved was seen, and the methodological difficulties of achieving this are formidable given the need to respect client confidentiality.

Some measurement of clients feelings of being valued were possible from assessment tools used by providers although this appeared to be linked to changes in feelings of self esteem and self worth.

Data regarding the perceptions of the wider community regarding aspects of substance misuse was not seen.

Present provider reporting systems

The majority of providers have systems in place that try to measure the impact of their activities. Four significant features of these information systems were seen in virtually every provider. First, information systems rely in the main upon paper to capture initial data items and several providers accepted that data was not always rigorously captured if staff were busy. Second, they had as their main foundation an individual client record. Third, while the individual records used had many common features, each agency had created their own version so that slightly different data items were captured. Fourth, data was usually captured only in respect of immediate treatment offered and progress made; once the client left the auspices of the provider there was little data capture attempted regarding the client's subsequent experience. Several providers did attempt to gather follow-up data but response rates were generally low. This arose for a number of

reasons, but predominantly because providers were not resourced to stay in contact beyond the episodic care given and because many clients moved beyond the easy reach of providers after, or sometimes during, treatment.

Most providers offering active treatment to individual clients had systems to capture the progress that individual clients were making towards their self-declared goals. Three providers have well-developed approaches that offer a basis for measuring progress against individual aims, rather than against a priori goals. Typically, these systems rely on a baseline assessment of the clients' problems and aims at the commencement of treatment and then regular assessments of decreases in problems and attainment of goals at fixed intervals over, for example, one year. However, these systems are designed to guide the care of individual clients; they cannot easily generate aggregate data, for example to quantify, in some way, the amount of harm reduced or the increase in quality of life achieved within a community.

Whilst the study could not pursue this in detail, it is likely that a common framework for capturing such aggregate data could be developed and used consistently across Wales.

An assessment of value for money

Value for money is interpreted here in terms of cost-effectiveness. This is conventionally described in simple terms as the quantity of desired outcome, minus undesirable outcome, for a given quantity of input. In many instances within health and social care, the difficulty of measuring outcomes often leads to the use of 'proxy' measures, such as the quantity of process or output, instead of outcome (where specified processes are known to have high success rates).

The assessment of value for money, in the context of substance misuse treatment, therefore demands the following as pre-conditions:

1. agreement on desirable outcomes
2. agreement on undesirable outcomes
3. an accepted body of interventions of proven efficacy (with clear notions of suitable clients, range of needs etc)
4. an agreed set of outputs which are acknowledged to be reasonable proxies for outcomes
5. standard measures of inputs (financial, human resources, capital, etc)
6. data to quantify, and measure the quality of each of the above.

It will be clear from the foregoing that many of these pre-conditions cannot at present be met. In terms of (1), desirable outcomes, the different funding agencies have different notions of what they are trying to achieve, and often express them in the most general of terms. There is disagreement over the appropriate length of time before measurement should take place. Furthermore, many argue that services should aim to meet client-defined needs, with all the variability of type and degree that this entails. The definition of undesirable outcomes (2) is beset with many of the same difficulties. The difficulties

of (1) and (2) could to some extent be circumvented if there was an accepted body of effective interventions (3), linked to a notion of which clients, under which circumstances, would benefit from them. This is far from being the case at present, and although the National Treatment Agency and others are working to develop such an 'evidence base' it is currently limited, and difficult to apply in the varied circumstances of the different parts of Wales, different client groups, and individual client variability.

Outputs of service intervention (4) might be more easily defined, especially if they are linked to client specification. Several of the agencies interviewed were using similar templates for the assessment of clients' needs. If further developed and universally adopted – and that may prove difficult given the variation in agencies – they would offer a means for capturing the progress made by individual clients, against their own objectives, from which an aggregate 'value added'-type measure of effectiveness could be derived.

Measures of input (5) should be the easiest of the pre-conditions to achieve, given the introduction of common assessments of staff qualifications and experience which provide the basis for a standard 'currency' of human resource input. The final pre-condition – the availability of reliable and comprehensive data on the other five – is currently far from being met. However, this is to some extent a function of the inadequacy of the measures deployed and the lack of impact of the commissioning process. As the measures become standardized and meaningful, and as commissioners demand such data, one might expect the data gradually to be collected and made available.

In summary, therefore, it is currently impossible to measure the cost effectiveness of the substance misuse treatment services because it is impossible to measure their effectiveness at any level other than that of the smallest element – the progress made by individual clients. Comparison between providers, between therapeutic interventions, and any overall assessment is undermined by the difficulties identified. But progress can reasonably be made over the medium term, through two broad approaches. First, by the providers and commissioners jointly developing valid and practical measures of the 'value added' for individual clients; second, by applying the results of on-going research aimed at evaluating the effectiveness of particular interventions for particular client groups.

The commissioning process

In addition to the six areas set out in the terms of reference, the steering group indicated that it would welcome information gained by the study regarding the commissioning process. Although commissioning was not a direct focus of the study – being studied so that the behaviours of providers could be put in context – some observations can be made upon commissioning and these are set out next.

As seen by commissioners

There was much evidence that the commissioning process is presently felt to be ineffective as a means of determining or shaping service delivery. The process has still not recovered from the recent changes in organisational structures arising from changes

from health authorities, DAATs and LATs and the introduction of LHBs SMATs and SMAPs. Further, there was evidence that the different strands within commissioning were jockeying for influence, or were perceived by some commissioners (and providers) to be so jockeying. Health bodies for example worried about the increased role of those from the criminal justice system in commissioning services, arguing that the focus might shift away from "treating people" to "reducing crime". Some from a criminal justice background feared that greedy health services would soak up funds from local government and others in order to shore up failing specialist services. It was also alleged by some that the different commissioners regarded substance misuse services with very different levels of priority, with LHBs perhaps not devoting sufficient resources to it. The extent to which the CSPs had employed staff with a health background, or worked in partnership with the LHB, varied considerably, as did the closeness of links between the SMAP and the Health, Social Care and Well being Strategy.

One commissioner formerly engaged in a DAAT, on receiving the questionnaire, advised that his locality would not be in a position to complete it; the commissioning process had all but disintegrated in his locality as a result of the service changes introduced in April 2003. Little had been done to ensure an effective handover of information relating to the awarding of such contracts. Further there was an implication that the different inputs into the commissioning process were not fully understood and that the aims of the different partners conflicted. For example it was intimated that it was known that LHB's were under financial pressure but "they will not be allowed to snaffle drugs money to fund level 3 and 4 treatment services". Several other commissioners reported a similar inability to understand the challenges posed by substance misuse and to craft appropriate evidence-based specifications for services to which existing or prospective providers could respond.

There were concerns about the complexity of the commissioning process, aggravated by poorly developed planning processes, the development of new statutory services (such as Job Centre Plus), and the direct commissioning of projects by the Assembly Government. Some commissioners stated that the numerous processes should be streamlined through direct commissioning (i.e. by each of the individual players). However, most believed that joint commissioning was the way forward and were in the process of developing this. Some commissioners were about to recruit a Substance Misuse Coordinator to make this process work and compensate for the different agendas, priorities and inputs of the key players.

In several localities it was felt that the CSP had little idea about substance misuse services and the way forward was for the SMAT to preserve as much freedom for itself as possible.

Little assessment of needs had been attempted and that which did exist relied heavily upon the information supplied by providers, although a number had either commissioned the same consultant to carry out a needs analysis in their area or had undertaken some specialist work – for example in schools – to assess the nature and level of misuse .

There was evidence in three localities of commissioners actively seeking to make changes in voluntary sector provision in past years, although in two instances this was at the prompting of service providers seeking to alter service arrangements.

Problems cited by many commissioners included:

- a history of disjointed commissioning - with different funders pursuing different objectives, lacking an adequate needs assessment – resulting in the CSP inheriting an uncoordinated conglomeration of services, with no agreed set of priorities for the future
- the wider legal framework in which commissioning takes place, which focuses resources on offending (e.g. illegal drugs) to the detriment of services addressing alcohol misuse)
- the impact of recent structural change and the turnover of staff
- the lack of skilled staff able to be dedicated to the commissioning of substance misuse services
- the absence of information relating to need and to effectiveness of services
- the short term nature of much of the funding
- the lack of a "common language" around which commissioners could gather to cover the different impacts they were trying to have and through which these could be assessed
- the lack of capacity to meet needs meant that new voluntary organizations could secure funding from the community fund or other charitable trusts without their knowledge, without meeting safety standards and without working in a co-ordinated way.
- the need for there to be greater clarity about the different levels at which commissioning should occur – for example should residential and other specialist services be commissioned at an All Wales level?

Some commissioners, however, expressed hope that the commissioning arrangements would gradually improve over the next few years and were able to cite examples of a continuity of approach which was still building upon the work done by previous bodies. They argued that the current arrangements – together with the intention of bringing together many of the funding streams – now provided an opportunity to assess needs comprehensively, and then to develop an effective and coordinated pattern of services to meet the priority needs.

Commissioners stated that commissioning should be based on research about needs and that decisions about needs and priorities should be assessed locally. Some are looking to the future to develop better systems of identifying the services needed in their area, including:

- independent data about models of effective delivery/best practice
- audits of substance misuse (recorded on GIS)
- police, probation and community safety data
- LHB data
- data collected for the Health, Social Care and Well Being strategy

Whilst commissioners stressed the importance of local commissioning, decision making, participation, monitoring, evaluation and accountability, they also expressed the hope that WAG would invest in the commissioning process and share with them information they collect about substance misuse, including good practice, research findings, evaluation guidelines and benchmarking. Commissioners want guidance in interpreting government policy locally. Some commissioners referred to 'helpful' guidelines produced by the Welsh Drug and Alcohol Unit.

There are concerns about the agenda of the Welsh Assembly Government in relation to the SMARTs. For example, some saw it as looking at a treatment framework through the SMART on a regional basis, whilst SMAPs are developed locally. There was little understanding about the role of the SMARTs and their relationship to the national agenda and, indeed, little consensus about the value of a national commissioning framework.

Commissioners stated that to change a 'funding led and reactive' commissioning process into one that was more strategic required a commitment to a more flexible funding over longer time-scales and devolved responsibilities to the local SMATs to allocate resources in the most effective way.

Most commissioners pointed out that the continuous process of change and uncertainty is in itself resource intensive. As one commissioner stated:
"The assumption is that current services are sufficient and working to capacity, but we have a patchwork of islands of service that are fully stretched and with no capacity to grow".

Commissioners were critical of the inflexibility of the Drug and Alcohol Treatment Fund and the requirement to submit annual funding applications. They were also critical of the lack of capacity to do any substantial monitoring of projects funded through the DATF. One stated "we know the money is spent appropriately, but we don't know that the outcomes are any good".

As seen by providers

The characteristics described by commissioners were echoed by providers, almost all of whom were unhappy with the state of commissioning. The following quotes give a flavour of that unhappiness.
"The DAAT was beginning to be better at integrated commissioning, we have gone back seven years as a result of the re-organisation".
"Historically, providers have driven the concept of need, both numbers and needs assessment".
"The Community Safety Partnership has not done anything; the DAAT did come out every three months and offer help. The DAAT and the SMAT have been helpful". In terms of the commissioning process commissioners "don't understand addiction – they haven't a clue".
"Commissioners are interested in activity mainly, they are not much on quality".

However, one provider with broad experience said “commissioning in Wales is infinitely better than in England. The latter is too bureaucratic and can’t innovate – Wales can and it isn’t risk averse. Generally however, commissioning is poor, it doesn’t know how to judge services, it can’t judge quality or cost”.

Providers were critical of the short- termism that was displayed by commissioners who, many felt, misused their purchasing strength to dictate terms and avoid longer term contracts or agreements. Costings used, with one exception, did not allow for capital investment and proper management overheads and this was a problem especially for the residential sector where capital assets had to be maintained and developed. Further, costings did not always fully reflect inflationary pressures or the need for providers to remain competitive in matters of salary, training and other terms and conditions. Finally, as has been noted elsewhere, the costs of IT and data gathering processes have, with one exception, not been allowed for.

Providers and commissioners alike wanted the commissioning process to be transparent and “plan- led”. Many were critical of what to them appeared to be a process of top slicing that has funded projects like the Rhondda Initiative and INCLUDE (funded directly by the Assembly Government) and also of the process of commissioning and funding Kaleidoscope (by sharing the costs equally across “Greater Gwent”).

Providers were not persuaded that the approach taken by commissioners to their services in respect of scrutiny were also applied to statutory providers. They commented that they felt their activities were intensively monitored compared with the level of scrutiny applied to statutory provision. A number also felt that their levels of staff-training, supervision, and quality assurance, were not demonstrably matched by statutory providers and they would welcome generic monitoring systems that applied equally to both sectors.

There were concerns that support mechanisms that could help commissioners and providers are inadequately developed. APoSM’s role was felt to be unclear, and those who knew about it thought it met too infrequently, was unrepresentative, and did not consult or communicate adequately with commissioners or providers. One provider noted that they had never had any enquiry or information from any member of APoSM from the voluntary sector.

There was criticism of the SMARTs because their role was unclear. Some lacked clinical knowledge and communication with many commissioners to date had been limited, albeit within a relatively new service. Some of the larger providers are considering the development of a Welsh Substance Misuse Forum under the aegis of the Wales Council for Voluntary Action.

E. Lessons learned to inform similar projects

The study is required to comment upon lessons that might be learned for other similar studies and comment is offered below.

a) Accurate scoping of such studies is essential to ensure that the boundaries of projects are well defined. A key aspect of this study was the extent of duplication. The boundary chosen was duplication of services commissioned with two specific Welsh Assembly Government funds from only 16 providers. Services provided by other voluntary providers supported by other funds, or by the statutory sector, were captured only indirectly. The extent of services offered by other providers, whether funded by public funds or other monies, was not part of the study. Recommendations to add this knowledge to that gained via the study have been included in the report.

b) The arrangements for mobilising the study, given the known deadlines, could have been improved by having in place a process for the consideration and receipt of tenders, and for post- tender negotiations, that reserved the time of any key individuals necessary to agreeing the award of the contract. In the event the study commenced one month later than the planned target date, a reduction by 20% of the time available.

c) The study was prompted by concerns within the Assembly Government but its execution required the co-operation of a variety of players. This was forthcoming to varying degrees and perhaps this was influenced in part by the extent to which they identified with the need for the work. Although the Government clearly retains the right to initiate such work, there would be merit in seeking to agree the broad parameters of such work with key stakeholders. Ascertaining the capacity of bodies to be involved so that those clearly unable to respond in the timescales desired could be excluded would allow prospective tenderers an opportunity to consider their study methodology in the light of actors likely to be available.

d) Although the study team was able to undertake some limited piloting of documentation used to gather data, the overall timescale for the project constrained what could be done. Wherever possible, where similar work is being considered by the client, some time should be allowed in the tentative project plan for the piloting of survey tools.

e) The WIHSC team was not made aware of previous work which had been carried out in this area, such as the study by Edwards and Mason, either in the pre-tendering stage or immediately after commencement. It may be that this was a deliberate decision to avoid any influence upon the study, but in retrospect it would have been preferable for tenderers to be advised of such work and for its relevance to be included in the Terms of Reference.

F. Conclusions from Study

The strength and vigour of the voluntary sector in Wales

It was clear that the voluntary sector is making an invaluable contribution to the treatment of substance misuse in Wales. Its strengths include awareness of and sensitivity to local

needs; dedication to meeting the needs of individual clients; a strong focus on developing services and flexibility in responding to the diverse ad changing needs of a number of funders. Most organisations had in place good or developing systems of quality assurance. Collectively they are custodians for a substantial element of the skilled resource required to address the growing needs of people experiencing problems of substance misuse. Government presently depends in large measure on the contribution of this sector to help deliver its objectives.

The nature and extent of service available

The services available were a patchwork largely arising from historical and opportunistic funding decisions mainly driven by energetic providers. There was little evidence that conscious decisions had been made, for example to:

- determine the most appropriate balance between the extent of services for alcohol as opposed to substance misuse
- balance the amount of prevention, outreach/contact, active treatment and on going support
- evaluate the effectiveness and appropriateness of particular therapeutic approaches or service configurations
- ensure a minimum level of service by treatment type, locality or social group
- determine which services should be offered by the statutory sector and which by other providers, based upon their different skills and attributes.

The commissioning process had had limited impact upon the nature and extent of services. This arose partly because of the absence of a robust evidence base and partly because of disruption to the commissioning arrangements caused by re-organisation of the commissioning function in 2003.

Duplication of services

There is little evidence of any significant duplication of services, either within the voluntary sector or between the voluntary and other sectors. Even if there were, some duplication could be defended on the grounds of offering choice to clients and meeting their diverse needs.

Gaps in Service

Some gaps in service were reported. These included geographical gaps where coverage in some parts of Wales was limited, gaps in service to particular client groups, and the absence of services that were sufficiently timely.

The extent of integration and co-ordination of services

The extent of service integration and co-ordination is limited. Most voluntary sector providers have informal arrangements for accepting and making referrals with other voluntary sector providers that abut them in treatment or geographical terms. The very fragmentation of services - with the possible exception of one part of Wales – demands that any holistic treatment approach will involve a number of providers.

In many parts of Wales the degree of co-operation between the statutory and voluntary sectors falls short of what it needs to be in order to provide continuous and timely care. Few effective mechanisms for co-ordinating care between the two sectors have been seen, although there is widespread recognition of closer co-operation in areas such as sharing good practice, performance measurement and benchmarking, and developing new initiatives.

It is not clear whether co-ordination and integration of care, both for individuals and of services more broadly on a strategic level, is best achieved by intelligent commissioners designing this into their pattern of services and the working arrangements demanded of each component, or by key providers ensuring seamless care through their arrangements with other providers.

There appears to be a mismatch between commissioners wanting specific outcomes and providers wanting to meet specific client needs. There is also a lack of opportunity for the co-ordination of services, e.g. through representation on the SMAT. There is a lack of networking and benchmarking among providers within Wales and the UK. While there are good examples of voluntary/statutory co-operation, links between these sectors are poor and inhibited by lack of respect for each other.

Service quality and effectiveness

There are two very different concepts. Providers in the main had clear ideas about what made for quality services and in essence saw these as client- led and geared towards achieving client goals whilst valuing them as individuals. Their systems were thus designed to assess how well they performed in these terms. There were good examples of quality assurance supported by qualified and well motivated staff. However concerns were also expressed about lack of capacity, lack of guidance from commissioners, and the limited scope of regulation, all of which undermined quality assurance.

Effectiveness however has several possible interpretations of which three have been considered within the scope of this study: (1) ability to meet client expectations, (2) ability to deliver aggregate harm reduction/abstinence, (3) ability to deliver wider social benefits including community safety. If seen in terms of meeting client expectations and goals in discrete treatment settings, then most providers ensure this by comparing outcomes against the initial assessment. If however effectiveness is to be measured in terms of goals set by others, or in aggregate terms, for example to deliver sustained sobriety for 30% of the clients referred to appropriate programmes, then one-off exercises to attempt some assessment of their success in these terms could be attempted. Few presently however could cite their success rates, and those that were quoted varied widely. If effectiveness were seen however in terms of meeting wider social goals, such as improving health or reducing crime, then the mechanisms for measuring this presently do not appear to exist.

How effectiveness is measured

Effectiveness is presently measured at different levels of sophistication.

Most providers measure their effectiveness in making positive changes in the lives of their individual clients but only in respect of the particular services they offer. Commissioners, where they measure effectiveness at all, see this more as relating to achieving contracted deliverables such as target numbers of treatments or a given range of activity.

There is currently little attempt at measuring effectiveness in terms of the wider impact on individual quality of life, the effects on the families of mis-users of substances, and on the wider community and this is probably a reflection of the fact that commissioners have generally failed to set such targets. This in turn is reflects a variety of methodological challenges – how to gather relevant data, how to establish cause and effect – and also a philosophical reluctance to engage with *a priori* targets as opposed to those derived from each client's circumstances. Moreover , the data required to measure impact is held by many sources. There is a need for standard data and agreement about what measures are to be used.

Value for Money

As a result of the foregoing, attempts at assessing value for money are fraught with difficulty. If costing data were widely available, and robust, then some attempt could be made to assess the comparative costs of apparently similar programmes. But without some agreement on desired outcomes, the application of research to evaluate the effectiveness of particular interventions for particular client groups, and without allowing for different thresholds for allowing individuals in to programmes, such comparisons would be unhelpful.

There were few processes in place for assessing how different providers fared in terms of performance measures aimed at assessing value for money.

The commissioning process

There were widespread concerns, among both providers and commissioners, about the state of the commissioning process. These included:

- the adverse impact of recent structural changes upon personnel and previous established personal links and the lack of full time commissioners skilled in substance misuse
- a history of disjointed commissioning
- a perceived change in focus of commissioning towards dealing with criminal justice rather than treatment issues
- some protective behaviour among the different elements comprising the commissioning process
- the short –termism of funding streams and the lack of robust costing/pricing approaches
- an apparent lack of even- handedness towards statutory and voluntary sector providers
- a lack of monitoring
- the ability of Welsh Assembly Government to introduce new innovations outside the plan-led system.

G. Recommendations

Recommendations have been grouped into three parts to reflect the three main processes revealed in the study, policy making, commissioning and provision.

Policy making

1. Develop and test a commissioning framework

It is essential that the Assembly Government conclude and pilot current work to provide a commissioning framework for commissioners to employ – recognising that any framework is likely to change as a result of experience in use.

Such a framework should, among other things, address the following elements:

- a description of the commissioning work that should be done on an All Wales or UK basis, that to be done at the CSP level, and any that should be done at a regional level within Wales
- funding should then be allocated accordingly, without any significant additional 'top slicing' for provision except for clearly described pathfinder projects that command the support of providers and commissioners and arise from agreed plans
- an outline of the methods already available and being developed to establish "need" that adds to present data from different providers enabling unmet need can be considered
- a clear statement of the policy imperatives that underpin commissioning approaches in Wales, for example a) describing the approaches to ensuring that all communities in Wales have easy access to initial advice, b) describing either the key harms that are to be reduced or the key benefits that are to be realised c) indicating the balance aimed at in terms of service for individuals, their families and the wider community d) indicating the balance of services between alcohol and drug misuse e)setting out the evidence of service effectiveness that Government presently recognises
- includes processes for measuring long term impacts of commissioning policy at a communal level.

2. Consider whether the present regulatory framework for residential services is appropriate in terms of their role and economies of scale

Residential services offering treatment for substance misuse are currently regulated by the Care Standards Inspectorate for Wales and are heavily constrained by requirements that appear to be more related to residential and nursing home services. These, for example limit the number of "beds" on any one site to 16 in Wales and also specify elements of care and the domestic environment. Such standards appear designed to ensure quality services for people who, in the main, are receiving long term care. Residential services for people misusing substances are however generally of short–term duration and have other characteristics which do not sit easily with care policies designed to maximise personal independence and freedom. The Welsh Assembly Government should consider whether the residential care offered by providers specializing in the treatment of substance misuse require separate and distinctive standards.

3. Support a policy development capacity for the voluntary and statutory sector, in conjunction with other stakeholders to underpin APoSM and the policy making process and to improve service delivery

The development of policy in the area of substance misuse clearly requires extensive dialogue between the various stakeholders at the national and CSP level. Such dialogue would also be most valuable in the development, identification and dissemination of best practice, and in the development of human resource capacity in the sector. WAG clearly values a partnership approach between itself and the statutory and independent sectors in relation to the crafting and delivery of policy. Other stakeholders in academia and the professions also have a contribution to make. WIHSC is aware of the value in other spheres of "confederation machinery" which brings these together for policy and services in respect of children and young people. Consideration should be given to the development of a similar capacity in the field of substance misuse. This would enable providers to share experience, be party to the commissioning of research, and to feeding in to the policy-making processes.

4. Create and support a benchmarking capacity for all providers for the whole of Wales, extended if possible to include data from English voluntary and statutory providers and also data from commissioners.

Providers seen were operating largely in isolation, with minimal opportunity to compare practice and performance, either within the independent sector or with statutory providers in Wales, or more widely across the UK. The establishment of a benchmarking service routinely producing anonymised performance data would offer a means by which providers and commissioners could compare their performance with that of their peers. A range of data is already collected nationally and it should be possible, working with the two sectors, to develop this to inform such a service.

5. Commission a project designed to assess the working relationships between voluntary and statutory providers.

Tensions were noted in some parts of Wales between these two sectors. The extent of the problem should be further assessed and, where necessary, steps taken to improve the sharing of territory, to increase knowledge of respective services and roles among all providers, to improve referral processes, and to increase organisational respect. This is probably a task that is beyond the resources of individual CSPs. and would benefit from an all-Wales perspective.

6. Clarify the aims and purpose of NAW funding streams and consider whether the influence over service development that government needs can be assured by other means so that the number of funding streams can be reduced and commissioning simplified.

Most providers were dealing with a variety of funding streams at considerable administrative and financial cost and the two streams employed by the WAG did not appear to be serving a purpose that could not be achieved by other means.

7. Promote further the remit and working of APoSM to engage more fully the different constituencies able to contribute expertise to its work.

Providers were aware of APoSM in general terms but were unclear of its remit and work programme and the routes through which they might offer information or comment upon

its proposals. Possible ways in which its work may be drawn to the attention of a wider audience might include:

- the creation of a web site as part of the NAW site and its existence made known
- the circulation of papers by email to a selected mailing list of providers
- a short newsletter to the Chief Executives of providers expressing a wish to receive it.

The relationship of APoSM to the body suggested in recommendation 3 above should be considered.

8. Government, in conjunction with other UK government departments and Welsh stakeholders, should make known the on-going programme of R&D designed to improve knowledge about the effectiveness of different treatment approaches.

Knowledge regarding the evidence of the effectiveness of different treatment approaches appears to be limited and partial within Wales with few providers routinely tapping into up-to- date sources of reference. The WAG should establish the knowledge needs of providers and commissioners, and consider how they might best be met. The role of the National Treatment Agency in England is probably relevant here.

9. The role of the SMART should be clarified.

The precise remit of the SMART appears to be unclear to a number of providers and commissioners. Its intended role, and relationship with APoSM, CSPs and the SMATs should be re-stated paying careful attention to the proper allocation of advisory, policy creation and implementation, and service monitoring functions.

10. WAG should ensure that the service is aware of steps it is taking to improve the effectiveness of service delivery.

A number of initiatives are in progress to improve services in this area, however key players may not be fully aware of what is in train and WAG should ensure that consistent means of communication are employed to alert key stakeholders to these.

Commissioners

1. **Ensure adequate funding is made available through contracts for capital investment to maintain fabric and supporting capital items such as computer systems, and relevant overhead costs such as training and data provision**

Approaches to contract pricing are not always informed by an understanding of the elements of cost which providers need to recover in order to provide a quality and developing services.

2. **Adopt a commissioning approach towards residential services which is related to this specific service rather than being an adaptation of the spot purchasing applied to long term care of the elderly**

In addition to the matters of cost in recommendation 1 above, the quality aspects of residential services should be specified in a way that is more directly related to this particular service.

3. **Ensure that the different treatment approaches – but especially the skill levels and approaches used in counselling services - are understood in terms of their strengths and outcomes so that services commissioned are appropriate to assessed needs**

The study found a variety of treatment services being offered. For counselling services especially the skill levels, techniques and recognized qualifications employed by providers varied considerably. It was not always clear that commissioners were appraised of the reason why these approaches were being employed or their outcomes in terms of good client/counsellor relationships.

4. **Ensure that they are clear about the underlying aims and values of voluntary sector providers so that either these are re-inforced through their agreements/contracts where these are shared by the commissioner, or else are modified where the commissioner thinks necessary and the provider agrees.**

Different providers operate from different value bases in terms of their aims and processes and, in extreme cases, one provider's approach may run counter to that of others.

5. **Consider whether the present range and diversity of providers is a strength or weakness in terms of achieving seamless care and assess the opportunities for building in elements that aid such integration.**

Two parts of Wales are served by one large all- purpose voluntary provider that appear to encompass most services and thus afford an opportunity for much service co-ordination to be achieved within the provider. Other parts of Wales are served by several voluntary providers co-existing alongside each other where either those providers, or the commissioner, has to take prime responsibility for integrating service delivery. An assessment of the strengths and weaknesses of these two approaches in relation to different parts of Wales could be informative.

Yet however voluntary sector services are provided, good levels of integration with statutory and other providers remain necessary and practices that help ensure this should be strengthened and those that inhibit it avoided. A recent review of such factors[10] noted a range of these and those most relevant to this topic might include:

- Increased sharing of databases and agreed processes for data handling
- Written protocols, procedures and care pathways that straddle providers especially at key transfer stages when clients move between care settings
- Joint (providers and commissioners) production of documentation
- Creation of organisational and professional respect through specific programmes
- Creation/recognition of straddling roles that cross several providers or agencies
- Availability of arenas in which common policies can be crafted

6. **Design approaches to the specification of quality that have a degree of commonality across Wales and which include aspects shown on page 15/16.**

[10] Beddow, T, Longley M and Warner M.: *Achieving Seamless Care: A Review of the Organizational and Other Factors Affecting Community Health Services in Wales*, pages 59,60, 118; WIHSC, February 2003

Commissioner requirements in respect of quality standards were often difficult to discover and thus were unlikely to feature in adequate reporting systems.

7. **Commissioners need to have the resources and skills needed to support the commissioning process, including contract monitoring.**

A number of commissioners reported difficulties in deploying sufficient staff time and skills to the commissioning process, with such work frequently being but one of a number of tasks for key individuals. Commissioners should agree and provide the minimum level of effort and skill/experience needed competently to perform this complex task.

Providers

1. **Providers should review their costing data to ensure that prices charged bear an intended but defensible relationship to costs.**
   To date, the income received has often been related to a fixed sum that commissioners have available applied to the maximum throughput that commissioners can achieve. Necessary cost implications such as: essential management overheads producing and analysing data training staff and ensuring continuous personal development capital, for example, buildings maintenance and the acquisition or replacement of equipment have not always featured in negotiations about realistic prices. Should arrangements increasingly operate on the basis of specified inputs processes and outputs, providers will need to ensure that these key requirements are addressed.

2. **Providers should consider whether there is further scope for collaboration with each other.**
   The sector faces some common problems including the difficulty of attracting high quality trustees and the time and cost of improving management processes. There may be ways in which providers can work more closely to:
   Share trustees
   Share in the development of quality assurance and client treatment processes
   Share in the use of expensive IT equipment and scarce/expensive management skills.

   The study team believe that the above recommendations provide a solid basis on which to take forward further developments in the commissioning and delivery of these important services. It is clear that there is great enthusiasm among voluntary sector providers and a strong commitment from policy makers and a wide variety of statutory agencies to further improving the services on offer. The study team hope that this report will aid this task.

Appendix 1A

The Review of Substance Misuse Services: Welsh Assembly Government

Request for Information from Service Commissioners

Background

The Welsh Assembly Government has commissioned a review of the voluntary sector substance misuse treatment services operating in Wales. The Welsh Institute for Health and Social Care, part of the University of Glamorgan, is conducting the review. WIHSC is tasked to produce its final report by the end of March 2004. The project manager at the Welsh Assembly overseeing the review, with the advice of the Advisory Panel on Substance Misuse, is Mr. Philip Guy.

Tony Beddow at WIHSC is leading the team conducting the review. Other team members are Dr Marcus Longley, and Ms Katherine Hughes. Ms Marina Roberts is the project secretary. All can be contacted on 01443 483070.

The review aims to ascertain:

- the nature and extent of the services available
- whether there is any duplication of services
- the extent of the integration and co-ordination of services
- service quality and effectiveness, and how the latter is measured
- value for money.

Outline of the Review

WIHSC intends to arrange visits to, and discussions with, the main voluntary sector providers of treatment services related to substance misuse operating in Wales. These visits will take place in January and February 2004. In preparation for these visits, and to acquire some of the data needed to achieve the aims of the review, information is being sought from provider of services by means of the following questionnaire.

WHISC would be grateful if this can be completed and returned as soon as possible, and in any event no later than 16th January 2004. Faxed or electronic versions will be welcomed. If you would like an electronic version please contact Marina Roberts.

Guidance on use

1. Where data is not available at all, please enter N/A.
2. If data is available, but not exactly for the periods asked for, please insert data and state periods for which data applies.
3. If data could be calculated, but cannot be made available by the return date, please enter TF (to follow) and WIHSC will agree the date for its receipt.
4. Completed forms to be:
   Posted to Tony Beddow, WIHSC, University of Glamorgan, Glyntaf Campus, Pontypridd, CF37 1DL or email to ajbeddow@glam.ac.uk

Request for Information from Commissioners

Part 1
1. Please attach a copy of all 2002/3 and 2003/4 agreements made with the organisations in the voluntary sector providing treatment services relating to substance misuse.
2. Please outline all other contracts for substance misuse let with any other sector – by service, type, volumes and coverage.
3. Please summarise the data used to estimate the quantitative need for the service. Please cite sources for that data.
4. Please summarise the evidence/data used to specify qualitative elements of the service.

Part 2
(a) Why are the services described in Part 1 sought from providers in the voluntary sector?
(b) Were other potential providers in the voluntary sector considered to provide services?
(c) What other providers of services in this field exist in your locality?
(d) What is your assessment of gaps in provision that remain as a result of the 2003/4 contract in terms of: **Geographical coverage/access:**

Client specific needs, e.g. ex offenders, pregnant women, ethnic minorities:

The quantum of service relative to demand:

Other gaps:

(e) What means are employed to monitor the agreement? Who is involved in that process from the commissioner?

(f) How do you assess the effectiveness of the services commissioned? What impacts are you expecting:

Appendix 1B

Review of Substance Misuse Services: Welsh Assembly Government Request for Information from Voluntary Sector Providers

Background

The Welsh Assembly Government has commissioned a review of the voluntary sector substance misuse treatment services operating in Wales. The Welsh Institute for Health and Social Care, part of the University of Glamorgan, is conducting the review. WIHSC is tasked to produce its final report by the end of March 2004. The project manager at the Welsh Assembly overseeing the review, with the advice of the Advisory Panel on Substance Misuse, is Mr. Philip Guy.

Tony Beddow at WIHSC is leading the team conducting the review. Other team members are Dr. Marcus Longley, and Ms Katherine Hughes. Ms. Marina Roberts is the project secretary. All can be contacted on 01443 483070.

The review aims to ascertain:

- the nature and extent of the services available
- whether there is any duplication of services
- the extent of the integration and co-ordination of services
- service quality and effectiveness, and how the latter is measured
- value for money.

Outline of the Review

WIHSC intends to arrange visits to, and discussions with, the main voluntary sector providers of treatment services related to substance misuse operating in Wales. These visits will take place in January and February 2004. In preparation for these visits, and to acquire some of the data needed to achieve the aims of the review, information is being sought from provider of services by means of the following questionnaire.

WHISC would be grateful if this can be completed and returned as soon as possible, and in any event no later than 16th January 2004. Faxed or electronic versions will be welcomed. If you would like an electronic version please contact Marina Roberts.

Guidance on use

1. Where data is not available at all, please enter N/A.
2. If data is available, but not exactly for the periods asked for, please insert data and state periods for which data applies.
3. If data could be calculated, but cannot be made available by the return date, please enter TF (to follow) and WIHSC will agree the date for its receipt.
4. Completed forms to be:
   Posted to Tony Beddow, WIHSC, University of Glamorgan, Glyntaf Campus, Pontypridd, CF 37 1 DL
   OR
   Faxed to Tony Beddow on 01443 483079
   OR
   Emailed to ajbeddow@glam.ac.uk
5. Any queries regarding the project, or the data required, can be forwarded to Tony Beddow, or Marcus Longley at WIHSC 01443 483070.

PART ONE

Please attach a copy of the agreement(s)/contract(s) that you have which are funded by the public sector for the treatment services that you currently provide.

PART TWO

1. Please insert the name of the organisation, and the name of the person completing the questionnaire.
Name of organisation:
Name of person completing the questionnaire:

Contact details:
Telephone: **Fax:** **Email:**

2. What treatment services does your organisation provide? Please describe in your own words all those provided in each of the following categories. Where these are provided with public funds please identify funder (e.g Local Health Board, Community Safety Partnership). Where these are funded by other sources, for example charitable sources, please describe source. Cash amounts are not required. In column 'No' please indicate numbers of clients treated in the financial year 2002/3 or the calendar year 2002, whichever you have data for.

	Publicly funded	No	Other sources	No
Information services:				
Advice/advocacy services:				

Counselling **Please describe each by type/model, e.g. 1-2-1, peer:**	
Residential services:	
Detoxification service:	
Supply of items **(e.g. needles, substances, other)**	

Support services related to treatment, e.g. housing, benefits, financial:				
Any other services:				

3(a). Describe any <u>formal</u> links that you have with other partners. Here formal links refer to arrangements captured in writing such as agreements to share services, or common ways of receiving or caring for individuals.	
Nature of Agreement	**Partner(s)**

3(b). Describe any informal links or arrangements that you have with other partners that help you to deliver treatment services.	
Nature of Agreement	**Partner(s)**

4. Describe the skills that are offered by your organisation in each of the categories that apply. Please give 'highest' level of skill offered by reference to qualification and any accrediting body granting its award.	
Medical:	
Nursing:	
Counselling:	
Psychology:	
Education/teaching:	
Peer group experience/support:	

Benefits advice:	
Housing advice:	
Employment advice:	
Other:	

5. Please categorise all the treatments that you listed in 2 above into all of the following categories.	
Fixed term e.g. related to a defined process or plan:	
Open ended:	
Geared to targets being achieved:	
Some other basis:	

6. Please categorise the treatments listed in 2 above in terms of those delivered.	
From one fixed point:	
From a number of fixed points:	
On a peripatetic basis including home visits:	
7. Please describe the population that you exist to serve. For example, is it defined by geography, by need, by some other characteristic or a combination? If you have different population for different services, please indicate.	

8. Please provide a profile of your service users for the period given in answer to question 2. Where not known please show n/k/							
By age:	**<14**	**14-18**	**19-30**	**31-50**	**51-60**	**60-70**	**>71**
By sex: **M** **F**							
By source of referral: **Self** **Family** **GP** **Hospital** **Social Worker** **Other (please list)**							
By type of substance misused: **Alcohol**							

Drugs **Other**
By length of misuse:

9. What protocols or treatment guidelines do you use to plan/guide treatments listed in answer to Q.2? Please attach a copy and state source if not shown.

10. What are you arrangements for following up clients no longer receiving treatment?

11. Please describe your care planning and case management arrangements. Please attach any formal policies in use and list those staff/volunteers currently acting as case managers.

12. Describe the form and extent of the care records used.

13. Please attach a copy of the organisation's written governance arrangements e.g **(a) its constitution or articles of association** **(b) its quality assurance processes** **(c) any clinical governance procedures including arrangements for supervision of those giving treatment**

Thank you for completing this form. Please return to:

Tony Beddow, University of Glamorgan in the FREEPOST envelope provided or by email to ajbeddow@glam.ac.uk

Appendix 2A
Interview Guide - Commissioners

1. Please outline how the commissioning of substance misuse treatment services now operates in this locality. What is your role?

    - Within what framework is the commissioning of services taking place?

2. How has the specification of the quantity of what you commission been determined?

    - What is the nature of the data? How is it interpreted, and by whom?

    - What evidence do you use to determine what type of services you commission?

    - For the future what data are you looking at to better understand the quantities needed?

3. What is your notion of a quality service?

    - How is this described in the commissioning document?

    - How is this assured from your providers?

    - Do you use any formal process of q/a?

    - If so describe its elements

4. How would you describe the impact you are trying to make, and upon who or what?

    - what time period do you need to be able to judge your impact?

    - what information do you use to measure impact?

    - what evidence have you gathered on effectiveness?

    - who sees the information/evidence and what use do they make of it?

5. What parts of the services commissioned do you judge to be effective in terms of 4 above and why?

6. What parts of the services commissioned do you judge to be less effective judged in terms of 4 above and why?

7. Are you aware of providers other than those with which you have a contract operating in this locality? How do their services relate to what you commission? Why do you not use them?

    - How do you relate to them?

8. What gaps are you aware of in service provision and what action would be needed to fill these?

9. How do you ensure that the treatment you commission is integrated with that given by others?

10. What duplication of treatment services are you aware of?

11. What is your assessment of the processes that govern commissioning, how should they change, what service changes have been made in the last 3 years, who initiated them. To what extent is it a shared process?

    - How do you ensure that you have available competent suppliers?

12. Issues arising from the questionnaire.

13. Any other points?

Appendix 2B
Interview Guide -Providers

1. Please outline the history and purpose of your organisation.

11. How big is that part of your organisation dealing with services provided from the NAW monies? How many staff, how many volunteers, annual income/turnover, clients do you have all together?

12. What evidence do you use to determine what type of services you provide?

13. How do you go about specifying the quantity of what you provide?

14. What is your notion of a quality service?

15. How is this described in commissioning documents?

16. How is this assured in your provider processes?

17. Do you use any formal process of q/a?

18. If so describe its elements.

19. How do you recruit, manage, train volunteers?

20. How do you get feed back from your service users?

21. How would you describe what impact you are trying to make, and upon who or what?

22. What time period do you need to be able to judge your impact?

23. What information do you use to measure impact?

24. What evidence have you gathered on effectiveness?

25. Who sees the information/evidence and what use do they make of it?

17. In terms of impact on individual behaviour, how do you keep track of this over time?

What parts of your services do you judge to be effective in terms of 12 above and why?

What parts of your services do you judge to be less effective judged in terms of 12 above and why?

Are you aware of any other provider operating in this locality? How do their services relate to what you provide?

How do you relate to them?

What is your assessment of the processes that govern commissioning, how should they change, what service changes have been made in the last 3 years, who initiated them. To what extent is it a shared process?

What gaps are you aware of in service provision and what would be needed to fill these?

How do you ensure your treatment is integrated with the work that others are doing for your clients?

What duplication of treatment services are you aware of?

Issues from the questionnaire.

Any other points?

Appendix 3
Schedule of those interviewed in Stage 2 of the study

Providers

Neil Carter	Powys Drug and Alcohol Centres
Melanie Perry and Tim Charlton	PRISM
Alan Andrew	Chooselife
Norman Preddy, Robert Salmon Ifor Glyn, Brian Williams	WGCDA
Stephen Lyons, Maggs Lyons, Lyn Walker	Inroads
Andrew Williams, Geoff Bell	Brynawel House
Mike Blanche Liz Ewers, Chris Lewis	DAFS
Roger Duncan, Jill Burton, Helen Spencer	Swansea Drug project
Martin Blakeborough	Kaleidescope
Lynden Finlay, Graham Menzies , Libby Fowler	Roserchan
Steve James, Rhoda Lazio, Claire Hill	Dyfrig House
Clare Williams, Rosemary Hunter Aneurin Owen, J.P. Williams David Brown, Tony White , Jody Mardula	CAIS
Peter Roberts	GAP
Jean Harrington Liz Begg	TEDs
Stephanie Hoffman Gail, Smith	Drugaid
Martie Spittle, Maureen Fyffe,	Cyswllt Ceredigion
Adam Weston	

Commissioners [1]

Sally Thomas and Rhys Sinnett	Pembrokeshire
David Evans	Swansea
Zoe Martin	Bridgend
Richard Owen	Wrexham
Peter Williams	Ceredigion
Ann Batley	RCT
Mike Gregory	Powys
Jean Roberts	Newport
Erica Painter, Claire Donovan, Jane Williams	Cardiff and Vale
Paul Osborne, Hugh Brunt	Caerphilly and Blaena Gwent
David Jeremiah, Kathryn Jenkins, Matthew Rue Andrew Mason (Kaleidoscope) Angharad Evans (Tai Trothwy)	Torfaen and Monmouth
Martin Riley	Neath Port Talbot

[1] Interviews were arranged through the CSP but a number of those interviewed were from specific agencies and indicated that their comments were not necessarily those of the CSP as a whole.