Manchester Metropolitan University

Evaluation Report

An Evaluation of the Pilot Telehealth Programme

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Change Grow Live

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Executive Summary

The Telehealth programme was developed and piloted by Change Grow Live (CGL), to explore whether an extended brief intervention, delivered one-to-one either virtually or over the phone would be successful in engaging those with mild to moderate substance use. We evaluated this pilot programme using pre and post design, with data collection taking place from August 2024 to January 2025. Individuals were assessed at the point of referral (baseline), and then again upon completion of the intervention (usually 6 weeks). A range of measures were collected during this period from well-being related indicators to a range of substance use measures. Measures of psychological health and quality of life were also included. A total of 20 interviews were carried out with 15 service users and five staff members involved in the delivery of the intervention. In addition, the evaluation team analysed the organisations own quantitative monitoring and outcome data. The baseline sample contained 108 participants, which contained completion data for n=18 and n=29 participants respectively for the WEBWBS and TOPs outcome assessment tools used in the study.

Overall participants described the Telehealth evaluation as impactful and useful in reducing their substance use, this was supported by the quantitative outcome data which showed reduction in use of 49% (alcohol), 32% (cannabis) and 89% (cocaine) respectively in client's frequency of use. There were also modest improvements recorded to mental health and reported mental well-being. Various positive changes were reported in service user's behaviours, attitudes and relationships including improved relations with family and friends, and healthier outlooks towards substance use. All participants said they would recommend the programme to others if they were in their situation. The demographic make-up of the sample supported the Telehealth assumption of need i.e. those in employment or experiencing a range of health-related barriers to service. A small minority met the tool indicators for mild to moderate depression. Some of the participants requested more sessions, but this varied across the sample depending upon the level of need. Some of the most important contextual factors of success were the quality of the staff, with most having extensive previous experience of working caseloads with high needs clients. The flexibility of the model was highly effective at meeting clients where they were, through aspects such as the online delivery, adaptability of course content, and the rapport building of staff. The practical aspects of the programme were found to be points of distinction. Telehealth was able to triage and treat clients rapidly, often in the same week which was reported as highly valuable by staff and service users alike.

Telehealth is also the only service provision of free remote intervention in the area which was a major point of programme distinction.

Introduction

Nationwide, there has been a sharp increase on the demands placed upon drug and alcohol services, with a 7% rise in the number of adults accessing treatment and support in 2023/24 compared to the previous year (OHID, 2024). This increase can, in part, be associated with the fallout of the Covid-19 pandemic, which saw an increase in substance use among adults in the UK and complexities in their needs associated with substance use (Boniface et al., 2022; Harris et al., 2024). The Covid-19 pandemic brought unprecedented challenges for drug and alcohol services, with interventions being quickly adapted into telehealth approaches, to ensure ongoing support was available for current and new service users (Mark et al., 2022). The research base on remote online delivery for substance reduction programmes is rather sparse. However, Howlett et al. (2022) conducted a recent systematic review of 62 studies on remote interventions that utilised brief behaviour change techniques (BCT)s. The study found evidence of widespread effectiveness with 76% of the studies being rated as promising or highly promising.

Telehealth is the provision of healthcare services remotely through telecommunications technology, such as through phone or video calls, text, app or e-resource communication, and has been shown to improve access to care (Oesterle et al., 2020). Service users have reported high satisfaction with telehealth interventions for substance use, particularly in situations where other treatment options are limited (Lin et al., 2019). The use of phone and video support interventions have also been identified as being as effective as in-person care for reducing mental health symptoms (Chen et al., 2022). During the pandemic, service users within CGL who transitioned to telehealth interventions for ongoing support reported feeling safe and supported by staff, experienced ongoing positive impacts on their recovery journey despite the social isolation brought by the pandemic, and found the approach more convenient especially for those who had caring responsibilities or worked, though some service users did miss face-to-face interaction and some reported inconsistencies in the care provided (Hayhurst et al., 2022).

Building on the success of the telehealth intervention during the pandemic and incorporating feedback from service users and staff, the organisation aimed to further develop this approach. They sought to offer a cost-effective and convenient alternative for engaging individuals who are harmful or hazardous alcohol users (those scoring 20 or below on the Alcohol Use Disorders Identification Test (AUDIT)), as well as those who use cocaine or cannabis (those scoring 4-12 on the Severity Dependence Scale (SDS)). The project aimed to provide extended brief interventions through phone or video calls. Extended brief interventions enhance simpler approaches by incorporating motivational techniques delivered in one or multiple sessions

(OHID, 2023). The telehealth extended brief intervention seeks to overcome barriers to access for those who cannot engage with in-person treatment due to employment, mobility difficulties, chronic illness, and caring responsibilities. It also provides an alternative model of support for those who may feel fear, shame, or embarrassment due to stigma within their family or community. The convenience of this model enables it to reach a much wider client base who may otherwise not engage in face-to-face support including those who want to change their relationship with their substance use but do not identify as having dependent or problematic use.

Overview of Telehealth Intervention

Change Grow Live's (CGL) Telehealth service is a telephone and online based intervention programme based in England, currently being piloted in Camden, Luton and Norfolk. It offers an alternative way of working at addressing substance use. The service was originally developed as a response to the service restrictions during COVID-19. It was designed both as an adult intervention to cater to those with mild to moderate substance use, but also as a form of prevention, by reducing the future burden upon higher intensity drug services. Currently the programme caters to the those using cocaine, alcohol and cannabis, excluding those with severe dependency as assessed using SDS and AUDIT. Referrals for the intervention come primarily through the CGL pathway with GP and self-referrals also being accepted on a smaller scale. Potential clients at CGL are screened via a questionnaire, and an assessment via a keyworker at the point of triage with those that meet the selection criteria being referred to the service via their referral pathway.

The intervention is facilitated by a team of experienced trauma informed recovery workers, who carry out a short but in-depth, bespoke 6-week intervention (which can be extended to 8 weeks with staff discretion). Telehealth is carried out on a one-to-one basis and is delivered exclusively online or over the phone, with a great degree of client flexibility. The programme is responsive to their individual needs and provides a combination of evidenced based modules, drawing on principles of cognitive behavioural therapy (CBT), motivational interviewing, trauma informed care, harm reduction and client centred counselling techniques. The programme modules cover a range of areas designed to maximise the positive outcomes for those experiencing problems associated with their substance use. These could include challenging thought processes, managing and identifying client triggers, providing information on cravings and patterns of substance use, improving client's meta-cognitive awareness, as well as harm-reduction practices. Outcomes and impacts including reduced substance use and improvements to well-being and quality of life are recorded via a range of validated tools such as the Severity

Dependence Scale (SDS), Warwick-Edinburgh Mental Wellbeing Scales (WEBWEBS) and the Treatment Outcome Profile (TOPS).

Evaluation Aims and Objectives

The primary aim of this pilot evaluation was to assess if the Telehealth programme was meeting its proposed inputs and outputs for the target population, as outlined in the CGL logic model (see fig.1). This evaluation and the related methodology drew extensively upon Humphrey et al. (2016) implementation and process evaluation (IPE) framework. This provides an empirical and tried and tested evaluative roadmap for the robust evaluation of any programme, from feasibility, pilot to efficacy. The 'IPE refers to the generation and analysis of data to examine how an intervention is put into practice, how it operates to achieve its intended outcomes, and the factors that influence these processes' (2016:7). Such a framework has provided a pragmatic and impactful evaluative tool across multiple fields from public health to education and policy. Contrary to other methodological tools such as randomized controlled trials (RCTs), IPE provides a means of exploring not only what works, but for who and under what conditions. This implementation framework grants a detailed, multi-disciplinary account of an intervention, ideal for future replication in other contexts.

The framework argues for a combination of methods and data points, which has been included in this report. This evaluation includes qualitative interview data both from service users, as well as CGL staff directly involved in the intervention and those at the level of implementation. This is combined with detailed monitoring data on the demographic background of participants involved in the intervention, alongside a range of robust quantitative measures of programme success.

The pilot evaluation followed seven primary research questions (based on the primary dimension of the IPE), which are outlined below:

1. Fidelity – how far was delivery of the programme in agreement with its design, identifying challenges and obstacles?
2. Dosage – was the amount of intervention received by individuals accessing the support appropriate for the level of need selected?
3. Quality – how well were the services delivered, including in relation to other relevant organisations and in accordance with professional standards?

4. Responsiveness – how well did the intervention engage with individuals with low to moderate substance use? Did clients see it as addressing their needs?
5. Reach – to what extent did the targeted people come into contact with the programme?
6. Service differentiation – in what ways (if any) was the Telehealth model genuinely distinct and innovative? Did it offer support in novel ways compared to other services in the sector?
7. Adaptation – has the programme changed from its initial design? What is the nature of these adaptations and the justification for them? Are they beneficial or detrimental to the running of the intervention?

Theory of Change

The following logic model as seen in figure 1 was developed by the wider CGL team. It covers the inputs to the intervention as well the range of expected outcomes, both short and long term. The version shown here is the result of a process of iterative refinement. This provides a visual journey of the Telehealth model, from referral to the various means of impact the programme was expected to achieve.

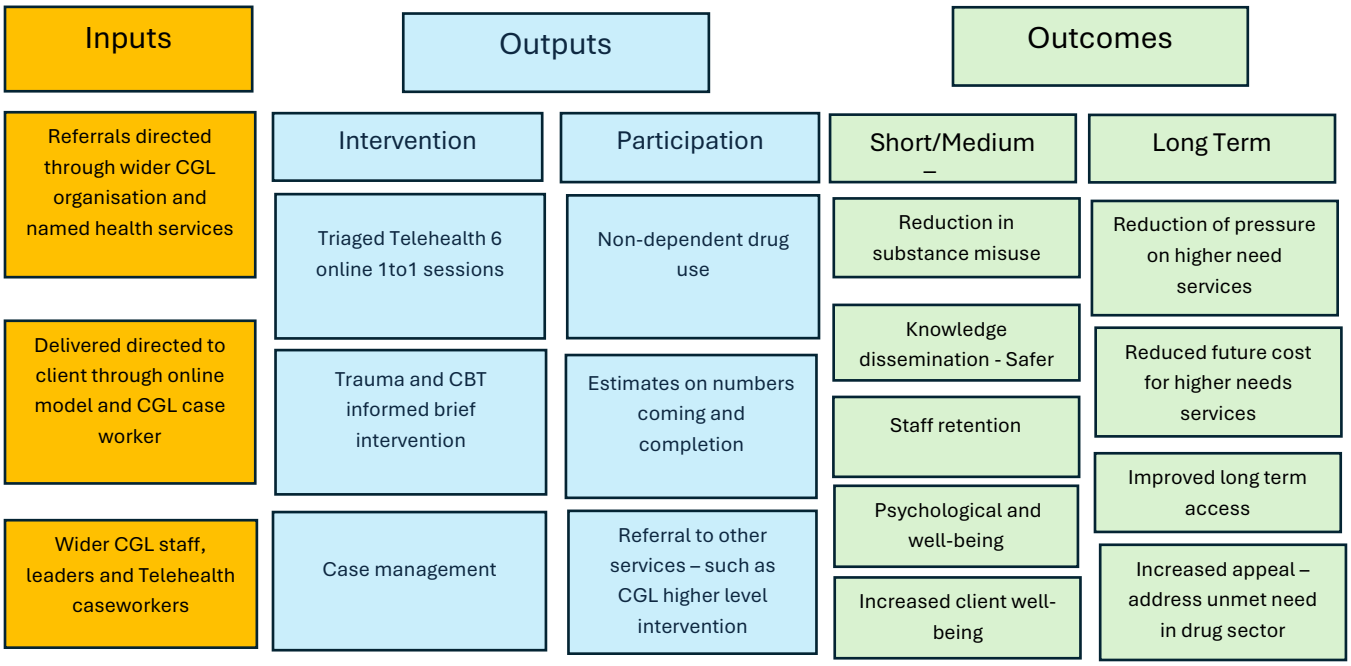

Figure 1: Telehealth – Theory of Change Logic Model

Summary of Telehealth Delivery Design

Inclusion and Exclusion Criteria

Inclusion criteria:

- Individuals scoring low to moderate on the Severity Dependence Scale (SDS)
- Adults over 18 years of age
- Those scoring 15 - 19 on Alcohol Use Identification Test (AUDIT)
- People who use cocaine
- People who use cannabis
- People using cocaine and alcohol concurrently, provided that the AUDIT score is below 20
- People who have no significant safeguarding concerns
- People with access to video and/or telephone calls
- People with identified mental and/or physical health conditions which are either well managed, not related to their substance use and/or the person is engaged with other health professionals

Exclusion criteria:

- Those under 18 years of age
- Individuals assessed as high risk according to the CGL referral pathway
- Those with high levels of substance use
- People scoring 20 and above on Alcohol Audit and requiring further assessment of dependence
- People with significant mental health or physical health which require additional case management or ongoing professional liaison
- People requiring medically assisted treatment (opioid or alcohol)
- People engaging in poly drug use
- People using crack cocaine
- People who are pregnant
- People with safeguarding/family concerns. For example, experiencing, or at risk of, domestic abuse or with current Child Protection or Child in Need plans

Data Collection

All of the interview data were analysed using a qualitative methodology referred to as thematic analysis (Braun & Clarke, 2006). These were defined by the core dimensions of the IPE, that is dosage, fidelity, quality, responsiveness, reach, adaptation and service distinctness. However, in line with the semi-structured nature and inductive traditions within qualitative methodologies more generally, additional themes that emerged during the analysis where also included. Two additional themes of change, and conflict and tension were added, bringing the total to nine. Each interview was transcribed verbatim, these were then read and reread several times. At each iteration they were coded using a variety of descriptive labels. As themes were identified, they were categorised and sorted, developed into a set of coherent narratives as reported in the finding section.

To gain a measure of engagement in the programme a range of quantitative data was collected and analysed in Excel, employing range of statistical measures such as mean, percentages, frequencies and distributional indicators. This included the number of referrals going into Telehealth, numbers of baseline assessments conducted and the figures of those that did not complete the programme or withdrew before it's completion. Data on the potential clients' needs was also recorded in a myriad of ways, these ranged from information regarding employment and housing status to mental and physical health, as well as more specific measures of substance use. To record the outcomes of the project the evaluation team utilised a series of measures that the CGL programme was already collecting which are outlined below (table 1.)

	Baseline	Completion
Severity Dependence Scale (SDS)	X	
The National Drug Treatment Monitoring System (NDTMS)	X	
The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)	X	X
Treatment Outcomes Profile (TOPs)	X	X

Table 1. showing Telehealth baseline and outcome measures

Quantitative Results

Recruitment

A total of 108 participants were screened from CGL's main assessment pathway, between 7/3/2024 to 12/09/2024, and were involved in the evaluation for the pilot Telehealth intervention. For the duration of the evaluation all referrals came directly through the wider CGL pathway. Of the 108 involved in the intervention, 15 (13.8%) of those who had completed and consented to take part in the evaluation during their assessment were contacted for interview. The cohort was drawn from the three evaluation locations, which were Camden (N=28), Luton (N=18) and Norfolk (N=62) respectively, with two individuals being transferred from an existing caseload at CGL. Table 2 (below) shows the figures for those involved or who had disengaged from the programme.

Service User Status	Total	Percentage
Referred back to CGL hub – failed to engage	4	4%
Referred back to CGL hub – not eligible	5	5%
Dropped out	34	31%
Incomplete – unknown	5	5%
Still engaging	28	26%
Complete - Telehealth	19	18%
Complete – brief intervention	12	11%
Transferred	1	1%

Table 2. Levels of client engagement

Descriptive Statistics

As seen in table three, the majority of the sample was male (77%), with females only making up 22% of the group. The average age of a service user was 37, with a diverse range between 19-78 years of age. The cohort was predominately White at 81%, with the next biggest groups being Asian (5%) and black (4%) respectively.

	n	%
Gender		
Male	83	77%
Female	24	22%
Not Specified	1	1%
Age		
<21	4	4%
21-30	38	35%
31-40	28	26%
41-50	20	19%
51-60	11	10%
61+	7	6%
Race		
White	88	81%
Black	4	4%
Asian	5	5%
Mixed	1	1%
Other/Not Stated	9	9%

Table 3. Participant characteristics

Additionally, as seen in table four, a large proportion of the population was reported as single (49%), with only 27% of the sample in some form of relationship. There was a relatively high level of additional need of various types. Of the 108 participants 47% indicated an existing mental health need, and 28% reported a preexisting condition or learning disability, with 47% disclosing that they were receiving treatment elsewhere.

	N	%
Marital Status		
With Partner	17	16%
Not stated	20	19%
Married	12	11%
Divorced	3	3%
Other	3	3%
Single	53	49%
Disability		
Behaviour and Emotional	18	17%
Learning Disability	3	3%

Mobility and Gross Motor	7	6%
Progressive Conditions	2	2%
No Disability	67	62%
Other	2	2%
Mental Health Need		
No	30	28%
Not stated	27	25%
Yes	51	47%
Treatment Elsewhere		
Engaged With the Community Mental Health Team	8	7%
Engaged w/ NHS Talking Therapies for Anxiety and Depression	1	1%
Need Identified but no Treatment	12	11%
Receiving Mental Health Treatment From GP	30	28%

Table 4. Additional demographics

Finally, as seen in table five, almost half of the sample (N=44) was engaged in employment at the time of the Telehealth intervention.

Employment	**N**	**%**
Economically inactive/Sick	7	6%
Not Known	1	1%
Pupil/Student	3	3%
Regular Employment	44	41%
Retired	3	3%
Unemployed and Seeking Work	5	5%
Unemployed not Seeking Work	12	11%

Table 5. Employment demographics

Telehealth Intervention and Outcomes

Across the evaluation period the programme delivered 199 sessions, 20% (N=40) over the telephone, 1% (N=2) in person with the majority, 79% (N=157) taking place via video. See figure two below for a breakdown of session durations, with 103 sessions lasting 60 mins. The minimum session time recorded was 5 minutes, with only 3 recorded sessions. The maximum session time was 90 mins, with 4 recorded instances.

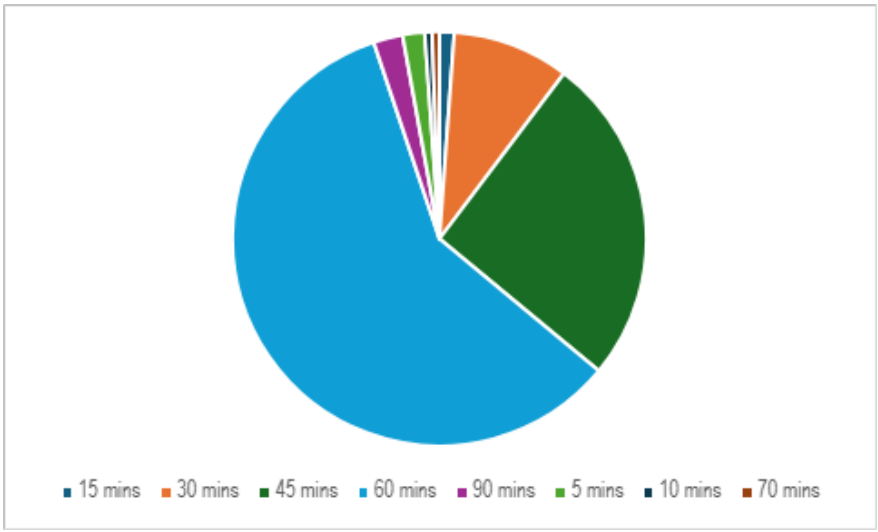

Figure 2. Distribution of session length

The SWEMWBS 7 is a 7-item scale designed to measure changes in the mental well-being within a general population - it is a robust and validated tool of evaluation and is scored on a 5-point scale. Participants are requested to rate a range of mental health related questions e.g. 'I am feeling optimistic about the future'. Each domain has a score range of 0-5, with the highest total score of 35. Positive scores are associated with improvements to mental health. At the end of the evaluation data collection period, 18 individuals had recorded scores at both pre and post. Benchmark scorings are as follows:

- a score of >18-20 is indicative of possible mild depression
- a score of 18 or less is indicative of probable clinical depression
- a score of 21-27 is within a typical range
- 28 and above for WEMWBS is suggestive of high mental well-being

Only N=4 (22%) individuals at baseline met the benchmark scores for clinical or mild depression, with most scores being moderate N=11 (61%) and N=2 (22%) already displaying high mental well-being. The baseline mean score was 23.2. The data demonstrated a significant improvement in mental well-being across the intervention period with the mean score at completion of 27.1, an improvement of 6.7 points. This is suggestive that the majority of the sample left the intervention with scores of high mental well-being. As seen in figure three (below) there was a general improvement across the majority of the 18 cases.

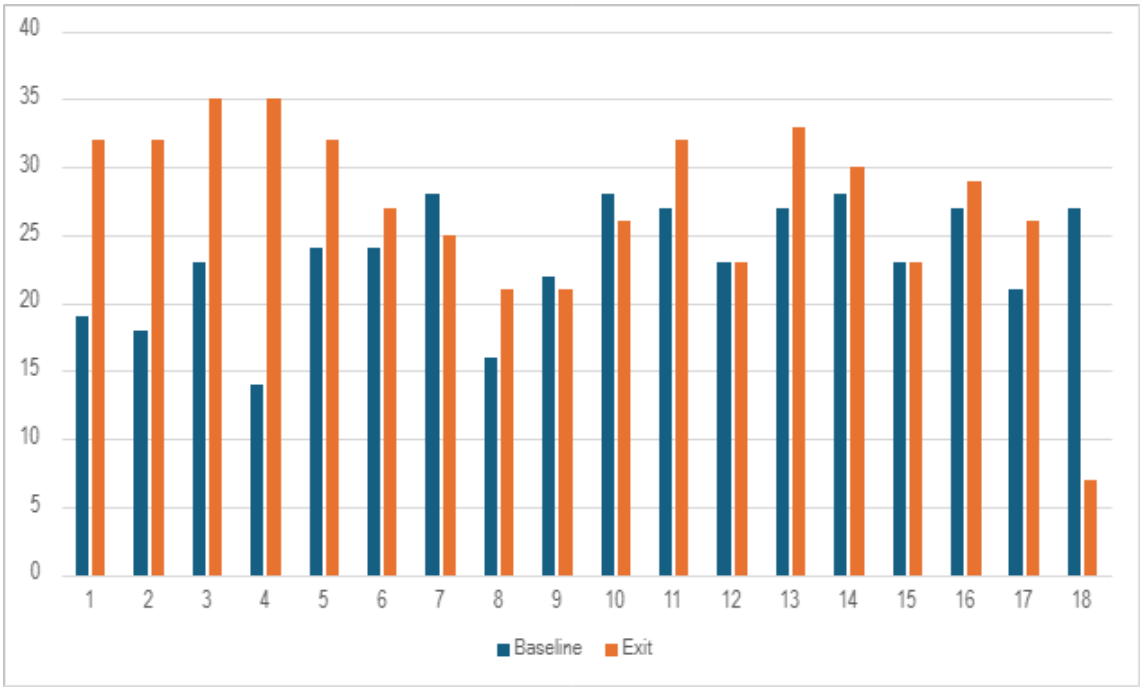

Figure 3. WEBWBS Comparison Scores

The second validated tool, the treatment outcomes profile (TOPs) is designed to track service users at various stages of their treatment journey. It provides a range of questions, recording changing levels of substance use, related factors such as housing status and education, and indicators of physical and psychological health. Twenty-nine participants completed the pre and post assessment tool for the treatment outcomes profile (TOPs). At baseline n=24 individuals reported using alcohol use only, n=28 cannabis only, n=13 cocaine only, with n=10 individuals combining alcohol with another substance. Reductions in substance use were significant across the three groups, with changes in use occurring across all three substances (alcohol, cannabis and cocaine). Average alcohol consumption averaged 12.5 units across the sample (see figure

4), which dropped to 6.3 units, indicating a 6.2-point intervention difference. Collectively 249 units of alcohol were being consumed by the sample, which fell to 126 units at exit a 49% reduction in use overall. The mean use cannabis scores (see figure 4) were 24 days (28 days maximum), dropping to 16.2 at exit, equivalent to a 7.7 treatment effect and a 32% reduction in overall use. This equates to 288 days of substance use at baseline and 195 at completion, across the total sample. Relatively few participants (n=7) used cocaine (see figure 6) in the sample; therefore, the minimum and maximum score is also included. As such, these results should be interpreted with caution. However out of a maximum of 28 days cocaine use, the baseline mean of 6.8 (Min 2, Max 14), decreased to only 0.7 equivalent use days at exit (Min 1, Max 4). This was an overall substance use reduction of 89%, or in total from 55 to 5 cocaine using days. Missing data on baseline alcohol use indicates two potential points, either clients were using cannabis or cocaine as their primary substance and compensating with alcohol, or clients entered accessed the Telehealth programme already abstinent from alcohol and wanted ongoing support.

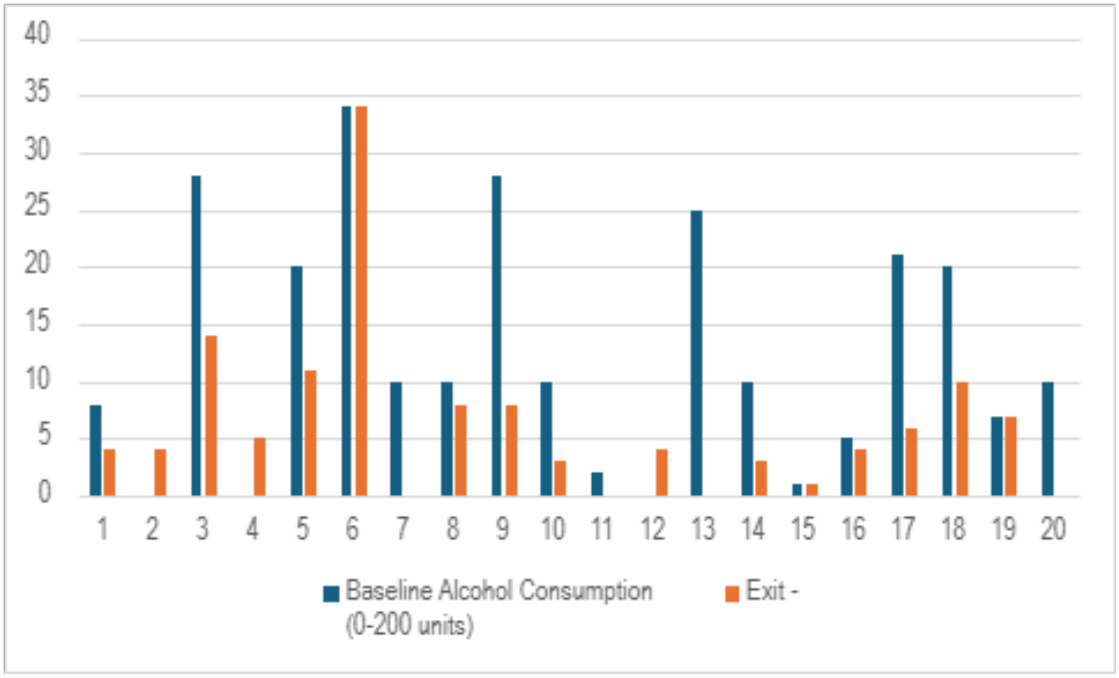

Figure 4. Alcohol pre and post

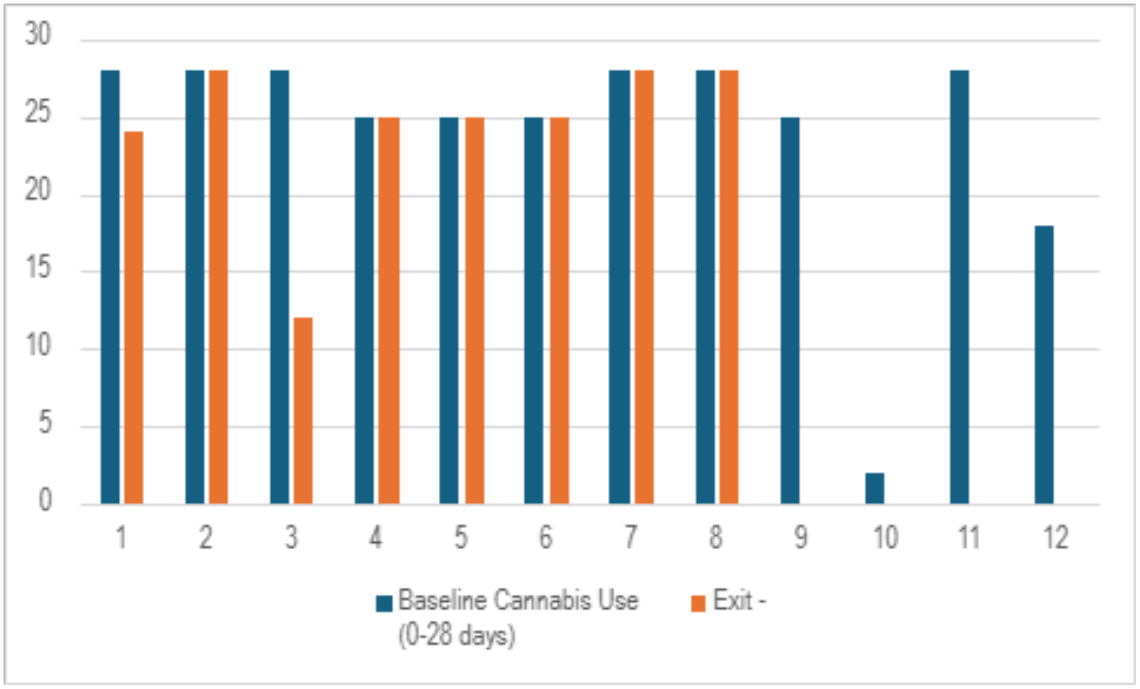

Figure 5. Cannabis pre and post

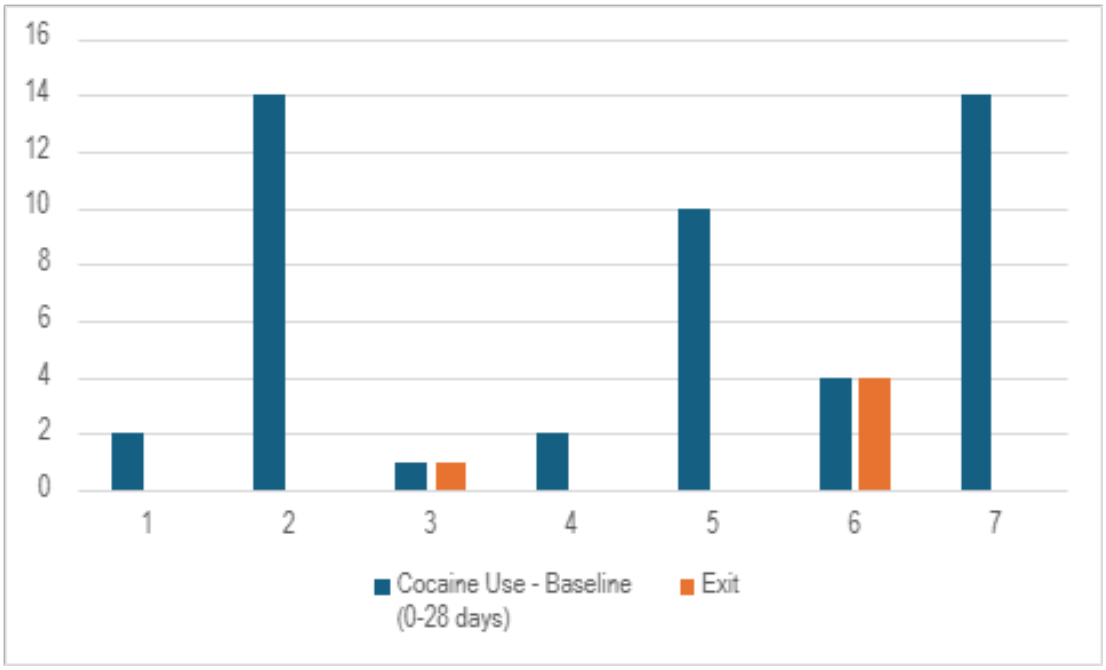

Figure 6. Cocaine pre and post

The tool also contains two other relevant measures, items on psychological health, and quality of life. Both of which are scored from 0-20, with 20 being the maximum positive score. The baseline mean score for psychological health was 12 points, which rose slightly to 12.89 post intervention. Interestingly the improvements were greater still in the clients perceived quality of life with mean scores raising from 11.6 to 13.3, a significant mean improvement of 1.7 across the sample.

Qualitative Results

As commented on by Pawson et al (2005:23) *"…interventions are fragile creatures, embedded in multiple social systems. Rarely if ever, is a programme equally effective in all circumstances because of the influence of context*". The purpose of a realist evaluation is to explain this wider nuanced context, to reveal the wider mechanisms at play, to address the questions of who this intervention is working for and in what conditions. The following qualitative sections are a reflection of that intention.

1. Change

The first theme presented through thematic analysis focuses on the type and degree of change reported as a result of the Telehealth programme. With no exception, all accounts from service users found the intervention to be useful and would have (and in many cases already had) recommended it to others. Change came in a variety of ways, for some clients this took the form of embedding the lessons from the sessions into their everyday lives: '*I've started to consider my drinking more, so, the thought process has changed I have started to use some of the tactics that my case worker and the booklet has suggested. The pause, delay, fighting the craving, putting something in place so the craving diminishes* (P4, Service User). In many cases, however, the changes could be far more personally meaningful and relate to aspects like improved relationships: '*Now that I'm, not doing it* (using), *I've noticed a difference in myself and my family do as well, they have really noticed a change in me. I feel fresh'* (P8, Service User). In another illustration a service user speaks to the improvements to his self-esteem which had been badly impacted by substance use prior to the Telehealth intervention

> '*Our first session I was a mess, I was on a bit of low I was feeling depressed, yeah since then I've started to get to grips again, I'm getting my life back, to being me again and not what I had become a few months ago*' (P5, Service User).

Changes could also cross into other domains, such as how service users were interacting with other aspects of the welfare state and related health services. In this case a client noticed improvements in their communication skills with other professionals '*What I've got out of this (telehealth) is to be able to communicate better, it has set me up for appointments in the future, with doctors, where I can be better talking to them*' (P13, Service Users). These positive changes were widely reported at the staff level too. All the Telehealth case workers would describe seeing a high degree of change in their clients as a result of delivering what they felt was a high-quality intervention:

> '*We are behaviour change service, when they start changing their behaviours they notice their drug and alcohol use changes because they put other things in place, they are the big things I notice. Client that came in "I don't think I want this service", then three sessions later they are going for a walk, cooking for themselves, they are going to the cinema, things they haven't done in years* (P2, Staff).

Staff accounts attested to the power of the intervention to create real changes in harmful habits and instil positive changes in the thinking of their clients. '*Changes are massive, my clients are reducing cannabis use, I didn't have users of cocaine that were still using, I can see massive changes, significant reduction. I can see the changes from session 3 from their mind* (P5, Staff).

2. Fidelity

The central premise of the Telehealth model was to engage with clients not typically engaging with substance use services, and to provide a convenient alternative for low to moderate substance use. Across the interviews with both staff and service users alike, there was wide agreement in the success of this model in reaching this group '*Many of my clients have social anxiety and would not be able to face a face-to-face services*' (P5, Staff). The models' format of direct and private one-to-one support was regarded as useful and important:

> '*I think if it was one on one, I would be okay, but I think if the (intervention) was in a group I wouldn't talk as much as I do, I'd be a lot more reserved if you see what I mean* (P5, Service User).

Many staff also spoke of the advantages of the flexibility of the Telehealth programme for their own well-being and work and life balance, *'I can plan my own timetable, I don't have days where I feel like I am going to explode, I don't have days I would rather cry than talk to clients, the balance of the work and life is huge, change for me is huge*' (P5, Staff).

The model reported to be using a range of CBT related techniques in the client sessions, and many spoke of their utility in their lives '*She would go through different strategies, of how like you could delay and distract yourself, and instead [of] going for a smoke, I could clean or go out for a walk'* (P2, Service User). Although there were differences in the specific usefulness of individual points of learning, there was widespread agreement from service users that the content could be applied to their lives and related difficulties. For example, case workers could work on a range of social strategies with their clients, '*we looked at ways, instead of perhaps going "its Saturday night let's have a drink" we could go out as a family and have a meal, have less drinks and have tea and coffee when you came home*' (P3, Service User).

There was little mention in the accounts on any significant obstacles to the Telehealth model. The design had widespread endorsement from both staff and service user, the only point of conflict concerned the speed at which the model was originally deployed. '*We could of hit the ground running faster, it was very strange, we learnt a lot of really good stuff in the induction, between learning that and delivering it to client was a good month. It's not like we forgot, but it's not as authentic as doing it the day before'* (P4, Staff).

3. Dosage

The theme explored if the degree of the intervention received was appropriate for the level of need found within the study sample. This was mixed across the sample with some feeling it was perfectly sufficient while other clients felt that six sessions were not sufficient to fully address their needs.

> '*One thing I would say is it isn't really long enough, I feel like I could do with more time sort of thing, talking to people, you get a 6 week programme and you saw a difference in*

myself in 6 weeks, I think if you like want more answers like, I think you need to look at it being a little longer ' (P6, Service User).

While for others six sessions as more than appropriate '*it covered all the bases really*' (P9, Service User). This was also reflected in the social value these weekly sessions provided the services users to reflect on their difficulties. For some clients who perhaps had higher needs, the six-sessions were not enough to discuss their concerns in depth, '*I think to be honest 6 sessions wasn't enough, I don't think it was enough to cover everything. When there's people with like mental health issues, struggling with life daily, to then sign someone off. Oh "you're fine", could be risky'* (P1, Service User). This tension between dosage and the clients differing levels of need was also echoed by some of the staff, '*what we found and is becoming apparent, is the clients on the top end of the substance dependency score are generally not achieving their end goal in the time frame, they are on their way, and they have a plan but they know where they are heading to. Next, but not there yet. Then those scoring on the lower half of the SDS, absolutely 6 sessions is fine'* (P1, Staff).

There were signs during the interviews with staff that this dosage difficulty was already being responded to by the staff. Staff spoke of the large degree of individual difference, '*I think it's okay, I think if there was a programme that was 8 weeks that would be even better. Everyone has a different level of adaptation, different capacity to change. For some people it would be enough even for 3 sessions* (P5, Staff). As a result, staff commented on the ability to request additional sessions from case workers as with this example, '*I actually got a client on session 6, and he's asked for another session to give him room to ask any questions which I said is fine. It's 6 sessions with the potential to be 8, but we have to have that conversation with them'* (P4 Staff). This dosage adaptation was clearly beginning to be embedded into the intervention.

4. Quality

There was universal agreement that Telehealth provided a good quality service to service users, although there were some differences in where that quality lay between staff and service users. For those delivering the programme there was a strong theme of confidence in the materials being used and the therapeutic approaches being utilised. A case worker here comments on some of the CBT related techniques which are seen as highly effective. '*How much do you want to stop? "All the time". Then that's where it is a challenge. When you are in a particular circle sometimes it's far easier for a stranger (for me), I don't know you, I don't have any expectations*

or judgments, I'm neutral' (P3, Staff). And here again with another case worker, '*I have a programme of scenarios that I go through, and triggers – are you aware sort of triggers? Not everyone has that knowledge. You are adapting the programme on the day* (P5, Staff). The effectiveness of these techniques is reflected by the service users, '*she's challenging, she doesn't just say what she thinks I want to hear, she will challenge me, she'll say "why are you doing that, why are you thinking this way?" You know? "You're a bright bloke". She's getting to the inner me, I think'* (P4, Service User). Although clients did not typically disagree with this staff perspective, there was a strong client theme around the crucial importance of the connection between staff and client which was at times valued more highly than course content.

Many of the of Telehealth case workers seemed to possess a range of personal qualities, outside of the treatment offer that were valuable to them:

> '*She was very helpful, we got on from the get-go, she sounded a similar age to me, it seemed like if I would tell little jokes in between to lighten things up she would understand and also which I really loved, she wasn't so formal, she was approachable, not like a robot. She would share about her week, and it makes you look forward to the sessions* (P7, Service User).

Case worker quality was tied to their rapid ability to build rapport and a meaningful connection with their clients, '*I think it was her as a person, I just felt really comfortable opening up about things I think it was just her. Some people got it, some people don't*' (P15, Service User). This quality of staff crossed many areas, from the relational as commented above to areas related to substance use. The sample commented numerous times on the negative impact of stigma, and on Telehealth's ability to bypass this barrier. A client here discusses this non-judgemental approach in action:

> '*Probably better than I thought, especially with it the self-assessment, and they were just really compassionate and empathetic. My parents for example are just saying things like "you need to drink less", well yeah, no shit Sherlock, like I haven't tried that before. Whereas (with Telehealth) I felt I like I had some constructive support'* (P14, Service User).

5. Responsiveness

This theme centred around the ability of the Telehealth model to engage with individuals with mild to moderate substance use, as intended in the treatment model. It seemed to be

responding in a few primary ways to the needs of this group. A dimension of importance was the referral process itself and the role it played in responding to those who engaged. Service users universally spoke to the efficiently of CGL and Telehealth in getting them the support when they needed it, from the first meeting to completion. A service user comments here on the ability to correctly and swiftly assess their need:

> '*From the moment I went into CGL and got seen, those two people that sat with me for two hours, tell um everything, there was no judgement, nothing, then very quickly I was given my case worker, I was given help very quickly, that was good, I needed it at that point* (P15, Service User).

One subject that repeated was the level of control that clients and staff had to alter the interventions to meet the changing needs of the clients. Staff felt this allowed them to respond effectively, '*I was able to tailor each session to the person, depending on their need and what they want*' (P4, Staff). These broadly aligned with the experiences of clients:

> *'You are completely in control with it, You can attend when you want, if you aren't feeling well or whatever you can rearrange, they are very understanding. It's like a modern kind of therapy. There is no stress whatsoever'* (P7, Service User).

The flexibility not only made the programme more appealing but could provide a valuable tool in sessions. A service user talks about how it granted improved understanding of course materials, '*there was one thing I got quite confused about and she obviously picked that up and slowed it down completely, so that was quite a good assessment for her to pick that up. Even thought it was going to delay our session; she was still happy to slow it down*' (P6, Service User).

Analysis of the staff accounts showed a high degree of confidence that the intervention was meeting the needs of the clients. '*When I do the closures I do a sneak peek at the feedback to see if there is anything coming through that I need to be thinking about, and being mindful of improvements etc, and the general consensus, and if the only request is to put page numbers on your workbooks, I think you are doing a good job'* (P1, Staff). There was wide endorsement from service users that the programme was meeting their needs, Firstly, with respect to case workers:

> '*I was pleasantly surprised to be honest with you, case worker has been absolutely superb, they have been very understanding, supportive all the way through , even when I felt down she has me feel a lot better about myself, reminded me, "look you've done this*

you've done that, you're two months clean!", pleasantly *surprised to see how much it could help, having someone there every week* (P1, Service User).

Secondly, as with regards to the content of the workbook to respond to their needs of substance reduction a client comments on one of the most effective strategies from the course, '*The 3 D's of delay, distract and decide, that's up on my wall. I could of still been using, but because I've got this in front of me, I can see it in black and white, not on an email. I can see it and maintain my positivity'* (P11, Service User).

6. Reach

This theme concerns whether the project was reaching the intended client group. Demographically the client group that emerged from the data seemed to be congruent with the treatment model. This often involved service users who hadn't engaged with a substance use services before, '*I've done therapies before but never for substance abuse to be honest, like I don't class myself as a full-blown alcoholic, that gets up and drinks, I felt a little silly referring myself but I thought: "No, I do need that support for it".'* (P7, Service User). The engagement from this new group of clients suggested it was '*a service for people that didn't have a service before*' (P1, Staff). Although the level of reduction varied, all of the service users mentioned reductions in substance use:

> '*Yeah, it has helped me to reduce, obviously I'm not totally off it (cannabis) but you know I've gone from smoking £30 a day to smoking like £10 a day'* (P2 Service User).

There was also a sense of high job satisfaction among the staff in the work they were able to carry out with clients:

> 'h*e actually sent me progression email yesterday saying he had just finished his engineering course, so a complete make over for him, complete change of direction of life. The beginning of the year he was homeless had nothing, didn't know what he was eating from day to day. Now he has somewhere to live, is back in touch with his son, sees him regularly, got a job, is safe and warm. I've seen a whole timeline from someone living rough, to being drug free and having a whole life ahead of them*' (P4, Staff).

One emergent aspect within the staff accounts was the constraints of the pilot itself and the conflict created in not being able to reach a wider client base, including those working in frontline services with long hours and varying shift patterns. The programme had revealed

further potential clients of need: '*We are missing people, because we haven't advertised it properly, we haven't marketed properly. And I understand why: it is a pilot. We are not getting to the education sector, we aren't getting to the fireman, the police, the NHS workers, the key workers. You're telling me they don't have issues?'* (P3, Staff). Many staff found it challenging to see such unmet need, but this had to be balanced with the practical limitations of the pilot, '*At the moment we are only getting people transferred from the main CGL services, people that come in for assessments. Now if we were allowed to advertise in GP surgeries and allowed to advertise in pharmacies saying "This service is available", I think we could reach all the right people.*' (P2, Staff).

7. Service Differentiation

This theme presented findings surrounding the potential distinctiveness of the model: in which ways it may have been new and innovative compared to equivalent services. Participants often spoke at length on the relative absence of services more generally in the welfare and substance reduction space. In this example, when asked if there were any equivalent or related services in their area one staff responded simply with '*No, nothing'* (P4, Staff). And again, at another site '*We are the only substance misuse service in all of Norfolk'* (P2, Staff), though it's important to note that CGL is the only substance use service in Norfolk. There was the sense from the staff interviews that Telehealth was operating in a wider therapeutic space that was struggling to meet needs more generally. Many of the service users reported having only tried Telehealth, '*Yeah, it's the first time I've seeked help, at all...EVER*' (P10 Service User). This level of sole recognition could also be interpreted as a potential point of differentiation from other substance reduction services.

All the staff had experience of working in other in-person support roles within CGL and had insight into the services available in their local area. Where similar drug and alcohol services were present, there was evidence from both staff and service users that Telehealth was offering something different. From some of the accounts this distinction cantered on more functional aspects of the offer such as speed of the referral process e.g. when staff would contrast Telehealth with similar services they would suggest, '*What makes us different is they are in and out of treatment in 6 weeks* ' (P1, Staff), giving the impression that this level of service responsiveness was absent in other areas of the welfare state. There were also more treatment specific points of novelty. A case worker here refers to the power of using their relational approach with clients, as '*It gives people the chance to have some face-to-face*

contact, which I think other services lack because people have such huge workloads, so a lot of these people were missing contact in normal service' (P2, Staff). This combination of client centred approaches and having the time to get to know clients echoed across many of the service users:

> '*She always remembered what I said, making notes, she knew exactly what I said in the previous one, she would build on that report, relate them back to what I said and jog them in your mind' It's those little details that make it really helpful and the support that much better'* (P10, Service User).

8. Adaptation

Adaptation concerns the small changes that occur during the pilot phase in response to the range of challenges often experienced in the field such as in the programmes' operation. Any adaptations are reported alongside with justifications and wider impact upon the project. One of the themes from the staff interviews indicated that the workbook, the manual used by the caseworkers of Telehealth, had undergone changes prior and during the pilot phase, as new materials became available, and the organisation responded to client feedback. '*Alcohol has been updated, and cannabis and cocaine has been rewritten. Some of the old workbooks in Hertfordshire we weren't using, because it wasn't engaging clients that well, the understanding etc, we could put a better map in, same principle but using a different tool but still follows the same pattern'* (P1 Staff).

There was also a strong sense from the Telehealth staff that they were able to adapt their sessions to the client, that the sessions' content was not too constrictive: '*That's down to me having years and years of experience I can do that, a lot of group work, I can adapt to it. Some of the others are brilliant at their job but may not have the same level of experience, they just work by the workbook, and they might struggle when it comes to adapting a little more*. (P2, Staff). This freedom to adapt was felt to be positive:

> '*The script is fantastic, got maneuver room. We deliver quite differently but it's there in the background. It's also about life experience and how we see and perceive things'* (P3, Staff).

This flexibility of approach was valued by many service users, particularly if they were not engaging with some of the course content, '*It was more interacting with the case worker (*that

was valued*), like I say I gave up on downloading the manual, because there was so much of it, think we ran out of printer paper, there was a drink diary there which I kept and bits on health'* (P3, Service User).

9. Tensions and Conflict

This theme outlines the main tensions that emerged in the data set, between staff and service users as well as across each group. The first topic that emerged was the difficulty in measuring the effectiveness of Telehealth at the individual level because of the six-session format. Even if the sessions were highly useful, sometimes clients had not yet had time to put the learnings into practice,

> '*I don't know, I mean I kind of know through the 6 weeks, only time will tell now. Oh, time will tell, next time I have a drink will I be able to control it? I don't know yet?* (P10, Service User).

Service users came to Telehealth at various points in their recovery journeys and this could present challenges to case workers. In this example the service user was already abstaining, '*thing is with my case worker, because I haven't relapsed, she struggles with information to give me, think she is normally got people telling her "I've done this, I've done that, because of that etc". I think it's harder for me, because I've found ways myself of dealing with it. She will tell me to do things, and I would have already done that*' (P15, Service User).

Not only were the client's recovery points differing but there were also some variations in the reported learning styles which could create tension and challenges for case workers: '*The bit that I didn't take much from was the workbook, but I think that's because I am different type of learner. Maybe could be a bit more interactive*' (P7, Service User). The flexibility to adapt to clients learning styles, as a staff member did in this instance, relied on the skills and relationship that the staff member had with their client.

The final sub-theme within this section relates to professional boundaries. It should be acknowledged that for the majority of the staff boundaries were not considered a major point of conflict. However, staff had the time to intimately get to know clients and many workers were texting clients regularly outside of sessions, further embedding a relationship of support. Among staff, a small minority highlighted elements of concern for some of the clients who had grown accustomed to the high level of support they were providing. '*I feel a little worried for*

*him (*the client*) if he didn't have someone to talk to, if I didn't refer to some kind of talking therapy, that he couldn't keep similar support that what I was giving him, what would happen to him?* (P4, Staff).

Conclusion

The original Telehealth ToC (see fig 1) contained a series of short- and long-term outcomes. Due to the limitations of the evaluation, chiefly, the delay in the pilot being embedded, the small scale, and the short timescales of the evaluation, it is not possible to speak to the long-term goals of the intervention such as a reduction of pressure and cost, typically placed on higher need substance use services. Further longitudinal evaluation work will need to be carried out, with larger sample sizes to be able to record such long-term changes. However, this piece of work can certainly speak to the range of short-term objectives.

A realist evaluation speaks to the 'why' of programme effectiveness, not merely to the degree of change. There were a range of pragmatic points of distinction to Telehealth that appeared to be underwriting its success. It was a free programme, with a rapid referral process. It was not unusual for clients to be triaged and begin treatment in the same week. When this is understood in a wider context of austerity and NHS waiting times of months, to, in some cases years for treatment this was a real point of difference. Workloads were relatively small, which gave the staff time and flexibility to work around their clients. Again, this level of client choice is extremely rare within the health care system. This was reflected in high service user engagement and their high levels of satisfaction with the intervention. While there were drug and alcohol services available to prospective service users across the three sites, Telehealth was the only remote intervention available, making it accessible to those who may otherwise not engage in support. The impact of these practical aspects to Telehealth cannot be underestimated, forming part of its unique offer to service users. It also represents a key point of learning if the programme is to be scaled up, that these everyday elements but crucially important factors, are not lost in that process.

One of the most dramatic factors in the findings of the Telehealth evaluation lies in the staff themselves. Caseworkers had the ability to quickly establish trusting and effective relationships with their clients, which was one of the most important drivers in correctly identifying and responding to the needs of the service users and reducing their substance use. The intimacy of the remote model allowed staff to be present with clients in their homes rather than a formal office setting, and the interpersonal style was relaxed, as one staff member noted, "The feeling

our clients get is that it's a therapeutic relationship, rather than a recovery relationship" (P1 Staff).

There was a series of essential abilities which these case workers seem to possess that the clients also commented on, these included empathy, compassion, commitment, resilience and integrity, alongside an ability to provide trauma informed care and emotional support. This was a testament to the quality of the staff selected to carry out Telehealth, but it also carries an important implication for the future of the programme. There were some suggestive signs in the service user interviews that some of the clients may have had higher needs than was originally recorded at their baseline assessments e.g. recent involvement with crisis team and disclosures of overdose. These disclosures were reported back to the key workers and the issues followed up in subsequent sessions as per CGL's safeguarding procedures. In this case, this was not a problem due to the staff members having extensive experience supporting clients with higher needs. While some service users may have initially downplayed their needs during assessment, future versions of the intervention should bear this in mind to ensure referrals can be appropriately triaged.

When considering the general aim of the programme, that is, to work with individuals with non-dependent substance use, the staff teams' extensive experience in complex needs caseloads provided a high level of confidence in supporting this group with mild to moderate substance use. Staff were trusted by the operational and leadership elements of CGL, which afforded a large degree of autonomy in programme delivery. This autonomy, alongside the changes staff witnessed among clients over a short period of time also led to a high degree of staff satisfaction, supporting the organisations' wider goal of staff retention (located within the ToC). This is particularly relevant in the wider everyday reality of a strained welfare state and high workloads across this sector. Telehealth staff had the space to get to know their clients, to not only assess their needs but to discover them organically in weekly sessions. A key aspect lay in staff having the time, and an appropriate workload of clients to successfully see changes in their clients. Staff understood Telehealth's limitations i.e. the unsuitability of those with higher needs, as well as its strengths and acted accordingly. This realism seems a core factor in what allowed the intervention to be delivered so well, '*It's a short sharp intervention, to get people what they need when they need it and nothing more'* (P1, Staff).

There was evidence that for some clients the intervention was too short, and they would have welcomed additional sessions, or for one session to be broken down into two to support their learning style and support their understanding of the content being discussed. The evaluation

team were aware that Telehealth was a six-session programme that could extend to eight sessions at staff's discretion, however, as the evaluation progressed it transpired that clients could receive up to 10 sessions. However, the interviews highlight how this was not effectively communicated to clients and is a point of recommendation for future iterations of the Telehealth programme.

OHID's guidance (2023) on remote interventions for substance use highlights the potential benefit of remote telehealth models for engaging people who need lower-level interventions, and this was supported in a variety of ways by the evaluation. For example, in the makeup of the sample itself, showing both high levels of employment and mental health needs. This was also reinforced in the qualitative interviews. The model appeared on the one hand to capture busy professionals who wanted to change their substance use but whose long working hours would have made traditional in-person appointments challenging to attend. While also capturing those who were economically inactive and experiencing various illnesses, who may have found attending in person a source of stress or shame. Although there were likely various distinct demographics involved, they all had one thing in common: this form of online delivery significantly facilitated their efforts to seek help.

Although designed for those with mild to moderate substance use, some clients did enter the programme already abstinent from substances. For some, this posed a challenge because the workbook and sessions were designed for those who were actively using and wanting to reduce or stop using. However, it is a point of importance, because it demonstrates that Telehealth is attracting an additional community of people who want convenient and accessible follow-on support to maintain their abstinence and recovery, outside of the traditionally available 12-step programmes. The skills of the staff and flexibility of the programme meant that some clients were offered a brief intervention with 1-2 sessions, but it does highlight that clients may enter onto the programme at different points, and future iterations of the programme needs to consider this in relation to staffs' skills and knowledge as well as the programme material.

Finally, although we must be cautious in overgeneralising the effectiveness of the Telehealth intervention, based on the evaluation data it demonstrated improvement across the board. As per the ToC there was widespread reductions in substance use which were significant across all three use groups (percentage reduction points of alcohol 49%, cannabis 32% and cocaine 89%) respectively in client's frequency of use, as well as noticeable increases in their perceived quality of life pre and post intervention. This finding was consistent across both assessment tools (TOPs and WEBWBS).

Another of the models' goals was to improve the psychological well-being of the service users and this was certainly supported by the assessment tools. The qualitative data demonstrated various experiences of positive internal changes and psychological improvements as a result of the Telehealth intervention by staff and service users alike. The additional ToC aim of knowledge dissemination and safer using practices, although not directly measured, can also be argued to have improved. This was reflected in the numerous changes in the habitual behaviour patterns of the service users (by staff and service users) and the widespread recognition around the informational usefulness of the workbook, such as in the increased understanding of the impact of substance use and the importance of harm reduction techniques.

Recommendations

Below is a list of recommendations for future improvements to the intervention, based on the evaluation data and the evaluation team's insights into the project. These could take the form of:

- Follow up sessions, both as a measure of assessing lasting harm reduction changes but also as means of relapse prevention.
- The development of programme material, or the development of a new programme specifically for those who are already abstinent.
- Akin to the therapeutic profession, creating a 'pre-closing session' to prepare the client for the end of the intervention.
- To summarise client progress from the previous 6 sessions at completion to consolidate learning and grant client's future reflective areas to work on e.g. mental health assessment.
- Knowledge exchange: shared practice groups between case workers, to ensure the currently high staff skill level is maintained as Telehealth develops.
- Improved communication from staff regarding the flexibility to extend sessions beyond six weeks to a maximum of 10.
- Reviewing client need in session 4 to determine if additional sessions may be required.
- Increased client and case worker flexibility in content e.g. covering week 3 over 2 sessions, or as one service user commented '*maybe build a pathway for everyone individually*' (P1, Service User). Session 1 could be utilised as an assessment period to decide in advance which areas clients would like to focus on or skip as appropriate.

- Establishing Boundaries: Determine suitable levels of staff communication outside of individual sessions to ensure both staff and clients are properly transitioned at the conclusion of the sessions.
- Closer relationships with other related third sector services organisations or community services e.g. civic groups such as community gardening that might be further beneficial to client's well-being.
- Course content could be further modernised, '*a workbook like an interactive PDF or an app you can work through as sessions/learnings, like a course kind of thing. That might have been easier to follow, to get ready for the sessions*' (P14, SU).

Limitations of the Study

There were some significant limitations to the Telehealth evaluation that must be acknowledged. One of the most pressing was the size of the samples, particularly of those captured in relation to the outcome tools. Although it is beyond the scope of any pilot to demonstrate true causality (which need large sample and effect sizes), future work will no doubt address this issue. Additionally, it was not possible to speak with service users who declined or dropped out from the intervention. As a result, this may have skewed the data, which were drawn from a purposive sample composed predominately of those who had successfully completed the programme. Capturing the views of those who declined Telehealth may provide key learnings for any future upscaling and should be included at the next stage of evaluation. Finally, the absence of long-term data collection points on service user outcomes makes any claims of lasting efficacy impossible to assess.

Implications for Policy and Practice

Implementation of the Telehealth model has significant implications for both policy and practice. The Dame Carol Black review (2021) review highlights the importance of prevention programmes, and the telehealth model can play a crucial role in delivering these programmes, particularly for young people and other at-risk groups, by providing accessible and engaging prevention education and support. The absence of waiting times for this model means that service users can receive timely intervention without the delays often associated with traditional in-person services. This can lead to quicker treatment initiation and better health outcomes.

Telehealth makes support more accessible to a broader population of substance users, especially those who are geographically isolated or have limited support services in their region. It overcomes barriers to access for those who are less likely to engage in support for hazardous substance because of economical, familial, racial, gender and societal barriers. This model also reduces the need for physical infrastructure and travel, making it cost effective, while also being a sustainable approach to treatment and support. By demonstrating tangible benefits such as reduced costs and improved access, the model's cost-effectiveness and efficiency make it easier to justify funding and support from commissioners and other stakeholders.

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