Evaluation of the Children and Young Persons' Outcome Monitoring Tool

By

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Introduction

In December 2015, Kate Williams (Aberystwyth University) and Katy Holloway (University of South Wales) were commissioned by Welsh Government to undertake an evaluation of Phase 1 of the pilot of the Young Persons' Outcome Monitoring Tool (YPOMT). The results of the evaluation are presented in this report. The Executive Summary provides both an overview of the background to the pilot and a summary of the methods used in the evaluation, highlights the key findings and makes tentative suggestions to guide Phase 2 of the pilot.

Background

The Welsh Government's Substance Misuse Delivery Plan 2013-15 (2013) included a commitment to design a tool to measure distance travelled for children and young people in substance misuse treatment. In Wales, children and young people includes anybody 17 years or younger in line with the United Nations Convention on the Rights of the Child (UNCRC 1989). Since 2008 the Treatment Outcome Profile (TOP) has been validated for use with adults (anyone over 16) who are in substance misuse treatment (see Marsden et al 2008). There has never been an equivalent tool for use with children and young people in Wales. In England there is a tool entitled the Young Persons' Outcome Record or 'baby TOP' as it is sometimes referred to (see Public Health England, undated). Unlike the adult TOP that tool has not been validated.

In 2014, in fulfilment of the commitment in the Delivery Plan, the Welsh Government (WG) began work to design a draft tool specifically for use by young people. The design process involved a group of stakeholders attending a series of workshops to discuss its shape and function. The tool was specifically designed to be something children and young people could both understand and relate to but which also captured information that would permit the Government to assess and measure distance travelled for children and young people in substance misuse treatment. The agreed tool was then seriously edited by the DIAB, a Welsh Government committee. The edited tool is very similar to the English Young Persons' Outcome Record.

The edited tool (henceforth referred to as the Tool) was piloted in seven areas (with 10 providers) for a 6-month period (September 2015 to February 2016). The results of this first pilot (or Phase 1) are the subject of this report. Phase 2 of the pilot is scheduled to run for a three-month period from June 2016 to August 2016. It is anticipated that the final version of the Tool will be ready for submission in October 2016 providing a six-month lead-in period ready for the formal launch on 1 April 2017.

Methods

The principal objective of the evaluation was to examine the Young Persons' Outcome Monitoring Tool and determine whether it is fit for purpose. To achieve this goal the evaluation adopted a mixed strategy approach that involved the collection and analysis of quantitative and qualitative data. It used a variety of data sources and methods of analysis including a focus group, telephone interviews, on-line surveys, and analyses of data collected using the Tool during the 6-month pilot period.

The focus group was held at the end of the first pilot period. The timing was useful in that the Tool had been in use for six months and the key strengths and weaknesses of it were well known by the participants. Thirteen people representing all seven areas involved in the pilot attended the focus group. Semi-structured interviews lasting on average, 40 minutes, were conducted with 12 key stakeholders from seven of the provider organisations and two commissioners. Three representatives of the Welsh Government also participated in a brief joint interview. The aim was to investigate the views and experiences of those people who use the Tool as part of their professional role or job.

Online surveys were developed for (a) young people with experience of completing the Tool and (b) professionals with a working knowledge of the Tool. The surveys complement the other methods of data collection and shed further light on use of the Tool in practice. Perhaps most importantly, the young person's survey also provided a voice to the very people that the Tool was designed for. The evaluation also included quantitative analyses of data collected using the Tool during the pilot period. The main aim of this analysis was to examine the quality and quantity of the data collected and to highlight key issues (e.g. whether the Tool was generating data amenable to analysis). It is important to note that the aim was not to assess the validity of the Tool (i.e. its ability to measure and monitor change over time).

The evaluation was conducted in accordance with the British Society of Criminology's Code of Ethics and University regulations. Ethical approval was obtained from Aberystwyth University's Research Ethics Panel. Care was taken to ensure the welfare of all participants involved in the research.

Key findings

Aims of the Tool

There was agreement among all those who participated in the evaluation that monitoring the outcomes (or distance travelled) of young people receiving substance misuse treatment in Wales was a core aim. There were differences, however, among respondents in terms of how they thought this data should be used. These differences seemed to reflect the roles that the respondents played within the substance misuse field. WG were clear that for them, the data would not be used to examine individual providers (perhaps a job for commissioners) but rather it would be used to measure progress and effectiveness across

the sector as a whole. Commissioners and providers, however, saw the Tool almost in clinical terms as part of the interventions undertaken with young people as well as being a management tool to assess effectiveness and improve provision. There was a general consensus of opinion among these respondents that the Tool should have relevance for each child and be used to help a child see his/her own journey.

Inevitably, there were differences among respondents on how much information needed to be collected. While WG were keen to minimise the burden of collecting data, providers saw the benefits of using one tool to collect data on a range of issues beyond the needs of WG. For providers, measuring progress would be more effectively achieved by gathering data on a slightly wider range of issues including the indicators set by commissioners and WG. The benefits, particularly in terms of the consistency that the use of a single tool could provide across services, were highlighted. However, it was also recognised that the Tool should not be used so rigidly as to interfere with the delivery of interventions.

The Target Population

Throughout the evaluation, questions pertaining to the target population emerged. Of particular interest was the finding that 18 people aged 18 and over were included in the data submitted by providers. While it may be expected that some young people aged 18 might be included (to support their transition to adult services perhaps) the inclusion of older people seems at odds with the Tool's focus on young people aged 17 and under. It was also of interest to note some confusion among providers regarding the appropriateness of the Tool for non-users (to capture preventions work with individuals for example). Clear guidance, either way, would help to ensure consistency across providers. Such guidance would also be useful to ensure consistency in the types of drug recorded on the Tool. Some providers, for example, recorded tobacco use while others did not.

Data issues

As part of the pilot, providers were required to submit electronic copies of their data to WG at regular intervals. The Excel Workbook was set up in such a way that made it difficult for providers to include data on multiple drug types. This resulted in confusion among the providers in terms of what to include and difficulty for the evaluators in creating a coherent database suitable for analysis. A discussion on this issue might not seem wholly relevant given that this system will not be used when the Tool is formally launched in April 2017. However, there are lessons that could be learned from this exercise that could feed into Phase 2 of the pilot and even the final version. Perhaps most importantly is the need to test the system prior to its implementation. It is important that the system is user friendly and that it enables consistent data to be collected across areas and providers. The elimination of missing cases is crucial for some questions, particularly those in the first sections of the Tool in which identifying information about the young person is collected. The date, for example, is of vital importance if change or progress is going to be effectively monitored.

There was general consensus among providers and commissioners that feedback and reports on the data would be useful not only for their own areas and services but also for the young people being supported. Some highlighted the benefits of feedback in terms of identifying examples of best practice that would serve to improve services generally across Wales. Others emphasised the importance of showing young people how far they have (or have not) travelled in their treatment journey. With these benefits in mind, developing publishing strategies (internal and external) might be a useful way of ensuring that knowledge is routinely disseminated and of encouraging the engagement (and supporting the progress) of the young people that the Tool was designed to help.

The way in which data can be extracted needs to be given a lot of consideration. Clearly WG will need their usual reports but the system also needs to be capable of producing management tools for provider and reports for commissioners. More importantly there needs to be a child-friendly way of displaying the data for use when working with individual children, in order to support their journey.

Completing the Tool

Differences were reported in terms of how the Tool was completed in practice. Variation was noted in terms of who completed the Tool, when it was completed, how frequently it was completed, and also in terms of what information was recorded on it. These issues are important and need to be monitored and controlled if valid comparisons are to be made. One solution might be to provide clear guidance that removes any scope for variation in implementation. Alternatively, additional fields could be added to the Tool to record variations that could then be controlled in any analyses. For example, if there is no requirement for the Tool to be completed with the young person, then a question could be added asking how in practice the Tool was completed with various options provided. This would help to ensure that entries completed in the absence of the young person are clearly identifiable.

The problem of missing data (or unanswered questions) was highlighted. Variations were noted in terms of how much data were included. These variations raise the interesting question of whether something is better than nothing. The danger of mandating complete entries could mean that the most chaotic young people (or the young people with the most chaotic lives) could end up being excluded from the dataset because they were unable to provide all of the answers at that time. It could also mean that valuable data are lost for the sake of completeness. One approach might be to make certain fields mandatory (i.e. those in the introductory section of the Tool) and to include a question that gives the worker scope to state whether or not the Tool has been fully completed and if not, the main reason why not (e.g. failure to attend, environment too chaotic, YP too chaotic, other).

One final point relating to missing data concerns the potential benefits of developing a system whereby static (unchangeable) data are transferred automatically from one Tool to the next. If a young person provides information about the age at which they first used various drugs on their initial form, is there any need for them to provide this again? One

exception to this, however, would be if the young person started using a new drug in the period since they last completed the Tool.

Key Recommendations for the Content of the Tool

In the body of the report and the conclusion and discussion section the reasons for the following recommendations are set out in full. Here the report will merely list the recommendations for the contents of the Tool.

Introduction

- Certain fields in this section of the Tool should be mandatory Client ID, Interview Type, Age, Interview Date and Sex fall into this category.
- The words 'Interview Date' should be simplified to 'Date'.
- To be consistent with modern terminology the word 'Sex' should be replaced with 'Gender' and the answer 'Transgender' should be added. The box should also contain the option 'Prefer not to Answer'.
- The question concerning whether or not the child has transferred to adult services should be replaced with:
    - Reason for exit: transfer to adult services, completion, moving to another service
- An on-line version of the Tool (maybe an app) should be designed. This should permit the information to be automatically uploaded thereby both saving workers' time and preventing errors in inputting data.
- If an on-line version is added 'On-line' should be added to the answers to the 'Methods Utilised' question.
- The Methods Utilised question might be replaced with 'Was the form completed:' and then the options: face-to-face; telephone; online.
- Each provider had different practices about the frequency with which they completed the form. It should be possible to enter all completions onto the system in order to download child-friendly outputs for use in treatment sessions. However, for data integrity it would be sensible to only count some of these for WG purposes. Therefore, there either needs to be a section on the form which records whether this version is to be entered into the official analysis or the system needs to automatically pick out those entries which appear at the correct intervals.
- For the second pilot it might be sensible to evaluate collecting data every six weeks instead of every four. However, the guidance notes should state that more frequent use is permitted where that might aid treatment or is required for internal purposes.
- From our research it is clear that there are many different ways in which the form is completed and it seems sensible to capture that information to inform the analysis. To facilitate these differences whilst still preserving the data there needs to be a new question added to the form asking 'How was the form completed' or 'Who completed the form': YP alone, YP with help from worker, worker with help YP, worker alone (after session). In the guidance it should be

made clear that the final option is only to be used if absolutely necessary e.g. to capture data on the most chaotic cases, when completing a form is not an option and might be damaging to the child and to the success of any intervention.

- ❖ Partial completions should be acceptable but the reason for the absence of all data should be recorded e.g. failure to attend, environment too chaotic, YP too chaotic, YP became upset during the session, other.
- ❖ There might be some advantage in recording the type of treatment: statutory, voluntary or both, though this is not a strong recommendation.

Section 1:

- ❖ It is very clear that the Tool should only ask for data from the last 7 days so the column referring to 28 days should be removed.
- ❖ The columns asking about how much was consumed needs to be more clearly wedded to the person's consumption therefore the question should refer to their use and be explicit about over what period e.g. how much did you use over the 7 days or how much did you use on an average day in the last week.
- ❖ The question about increase/decrease etc. needs to record 'on average' to ensure it was not affected by special events such as birthdays etc.
- ❖ The age first used is very important to record but should only be recorded on the initial form (unless a new drug is added to their repertoire). The information should automatically be added to review and exit forms through being linked to the child's ID number.
- ❖ This table should then have some new columns added to record:
    - the method used to take the drug (this would replace the present question in Section 2), the answer could be simply and effectively captured by use of a series of emojis depicting injecting, smoking, snorting, swallowing etc. and permitting the child to tick all those which apply.
    - the main method of imbibing the drug (if this is thought to be important, though the research suggests that this is probably not necessary) there could be a second column added asking this question.
    - how the drug was sourced - add the question 'what was the main source of the drug' with the possible choices of shop, online, friend, family, street dealer set out in the guidance.
- ❖ Finally, the substances in the left hand column need to be altered. Specific reference to opiates, amphetamines and cocaine should be removed as use of these substances was less commonly reported by this age group. The research also suggests that the broad NPS category should be replaced by specific reference to synthetic cannabinoids and mephedrone, which were the most commonly reported new psychoactive substances. Increasing the number of opportunities to record 'other' with a larger space to write in the name of the substance, is also recommended.
- ❖ The tables which help to assess the amounts used should be removed and placed in the guidance.

Section 2:

- Delete all the questions currently in this section. Injecting behaviour should be captured alongside other ways of taking substances (see Section 1 above). This would soften the question whilst still capturing information about injecting.
- In place of the present Section 2 it is suggested to include a new Section 2 recording information about other needs and risky behaviour. We would suggest the title 'Background to Substance Misuse'.
- This section should include the following:
    - A question about their accommodation status offering a choice of answers such as 'secure' 'temporary' and 'no accommodation'.
    - A question about their Education, Training and Employment status offering a choice of answers such as 'secure and attend regularly' 'secure but fail to engage' 'no ETE'
    - A question about how they fund their drug use offering a choice of answers such as including: borrowed the money, crime, sexual exploitation, part-time job, full-time job and other.

Section 3:

- This section produced most negative comments from workers, commissioners and the children themselves. The whole section needs to be re-thought and tied more clearly to health and wellbeing.
- The questions in this section need to be a lot more child-friendly.
- It became very clear that this section needed to be totally re-designed by deleting all of the present questions and replacing them with very different ones. The research found that Section 3 should include separate questions on each of the following:
    - physical health;
    - mental health;
    - emotional health;
    - relationships with family;
    - relationships with friends;
    - confidence; and
    - independence.

- The 0-10 point scales should be retained but emojis should be added to the beginning and end of the scale to make this simpler for younger children and those with learning difficulties. It was felt important not to focus on the emojis or to replace the numeric scale as older children would find this insulting, just a sad face at one end and a smiley face at the other would be helpful. In order to allow a more positive presentation it might be sensible to consider reversing the scale (10 on the left and 0 on the right).

Section 4:

Section 4 was welcomed and recognised to be very important to measuring outcomes. However, in its present form the research suggests that it may not be properly capturing outcomes. Therefore the section needed to be altered.

- The present question needed to be re-worded to ask something like 'About how many of your treatment goals do you think you have achieved?'.
- The verbal scale generally worked well though many children seem to struggle with the terms 'some' and 'a lot' as they found them too imprecise. The problem was that it was difficult to find simple replacements. The suggestion is that for the second draft they might be replaced with something like 'some, but not yet half' and 'more than half but not all'. However, it may be that after evaluation of the second draft it is necessary to return to the simpler form used in this iteration.
- Add another answer to the scale 'too early/initial' although many workers included turning up to interventions as a goal and, in that case, they would have achieved something even at their initial meeting.
- Add a question to ascertain how the child feels about their achievements.
- Add a question to the worker about how many of their goals the worker thinks the child has achieved.
- Finally, if the scales in Section 3 are reversed to put the positive answers first then the same should happen with these. Alternatively if the scales in Section 3 remain unaltered then these should not be changed.

Developing a Revised Tool

The report, and particularly this section, may give the impression that people are very unhappy with the work done to date. That is not true. Participants welcomed a tool for use with children and appreciated the chance to input into its design. There is real enthusiasm to create something very new and something that can deliver a flagship improvement to anything previously used by government in Wales or elsewhere. As with any innovation there is an understandable nervousness to change too much but it is only by exploring all issues that a really useful Tool can be created, one that is useful to the children, providers, commissioners and the WG, and one that is useful not just for now but also into the future. It is with that in mind that all the changes have been suggested, they arise out of the enthusiasm in the sector to create the best Tool possible, not just make do with what is already used.

The researchers recognise that this report suggests significant changes to the Tool but these have been led by suggestions from workers and the children. The changes suggested in the report will allow us to capture the experience of children's substance misuse more holistically and interestingly they are also changes which fit well with the recent Social Services and Well-being (Wales) Act 2014 and with the WG's extended entitlement programme (Welsh Government 2000, 2002a&b). The report sets out extensive changes which might be difficult to visualise and would involve a lot of work to design. If that is a stumbling block to using these suggestions we would be happy to offer to design a new Tool which would incorporate as many of these suggestions as possible.

Concluding Comments

This evaluation has considered whether the YPOMT is fit for purpose. The evidence presented in this report suggests that the Tool is not currently achieving its full potential. However, with some careful adjustments and the creation of clearer guidance there is scope to develop the Tool into something that meets the needs of WG, commissioners and providers. There is also scope to develop the Tool into something that meets the needs of the young people too. It is important to recognise that there is an opportunity here to develop a flagship Tool that better measures outcomes and supports children than either the English version which this draft so closely resembles or other available tools.

Above all, it is important to remember that these 'clients' are, as one respondent highlighted, "just children" who need to be safeguarded and treated appropriately. We therefore strongly recommend that any new version uses child-friendly language and is distributed to key stakeholders, including a group of children, for comments and testing prior to any future large-scale piloting.

1. Background

Introduction

In December 2015, Kate Williams (Aberystwyth University) and Katy Holloway (University of South Wales) were commissioned by Welsh Government to undertake an evaluation of phase 1 of the pilot of the Young Persons' Outcome Monitoring Tool (YPOMT). This report presents the results of this evaluation. The report comprises six chapters covering the background to the Tool, the methods used in the evaluation, key findings, conclusions and suggestions for phase 2 of the pilot. In this chapter we document the development of the Tool and consider the aims and objectives of both the Tool and this evaluation.

Background

The Welsh Government's Substance Misuse Delivery Plan 2013-15 (2013) included a commitment (12.4; page 20) to design a tool to measure distance travelled for children and young people in substance misuse treatment. Since 2008 the Treatment Outcome Profile (TOP) has been validated for use with adults (anyone over 16) who is in substance misuse treatment (see Marsden et al 2008). There has never been an equivalent tool for use with children and young people in Wales. In England there is a tool entitled the Young Persons' Outcome Record or 'baby TOP' as it is sometimes referred to (see Public Health England, undated). Unlike the adult TOP that tool is not validated.

In 2014, in fulfilment of the commitment in the Delivery Plan, the Welsh Government (WG) began work to design a draft tool specifically for use by young people. The design process involved a group of stakeholders (including service providers, commissioners, WG staff and academics) attending a series of workshops to discuss its shape and function. Over a series of meetings they agreed a tool. The tool was specifically designed to be something children and young people could both understand and relate to but which also captured information that would permit the Government to assess and measure distance travelled for children and young people in substance misuse treatment. The agreed tool was then seriously edited by the DIAB, a Welsh Government committee. It should be noted that the edited tool is very similar to the English Young Persons' Outcome Record.

The edited tool (henceforth referred to as the Tool or the YPOMT) was piloted in seven areas (with 10 providers) for a 6-month period (September 2015 to February 2016). The results of this first pilot (or Phase 1) are the subject of this report. Phase 2 of the pilot is scheduled to run for a three-month period from June 2016 to August 2016. It is anticipated that the final version of the Tool will be ready for submission in October 2016 providing a six-month lead in period ready for the formal launch on 1 April 2017.

The WG have stated that the outcome data collected via the Tool will be used to assess performance of the sector in general and not to assess performance of particular providers; they are interested in a strategic overview. Of course, WG recognise that the Area Planning Boards might look at the tool to evaluate the performance of providers at an individual level.

In discussions with the WG and with commissioners and providers, the new tool has often been referred to as being necessary in order to fulfil for children the role that the TOP provides in recording treatment outcomes for adults. In light of this, it is sensible to begin with a brief discussion of the adult tool.

Adult Treatment Outcome Profile (TOP)

The adult TOP is designed to measure change and progress over the treatment cycle of the adult. In particular, it measures aspects of an adult's substance misuse, injecting behaviour, risk behaviour, criminal activity, health and quality of life (see Marsden et al 2008, National Treatment Agency 2007).

The adult tool is not merely a tool to measure distance travelled, it is also intended to be supportive in a number of other ways:

It is intended as a clinical tool, to aid in the treatment itself. In this capacity it facilitates the: structuring of conversations between the user and his or her key-worker; setting of goal and reviewing of progress towards those goals; and workers in supporting, encouraging and motivating the user to achieve their goals and improve their lives over a number of key areas.

Within the treatment provider agency, TOPs data can be used in team meetings to discuss outcomes and explore how most effectively to intervene with each client. It can also be shared with the service user so that they can also readily track their progress and some areas use the tool more frequently than required in order to better support their clients. TOPs permits providers to identify and therefore replicate areas of good practice and to spot issues, problems or gaps in treatment or provision so that these can be addressed. These gaps may appear for particular service users or be broader, something they need to address by altering their provision.

Analysis of TOPs data allows providers to demonstrate to management boards, partners and commissioners the effectiveness of their services.

In the case of the provision of TOPs data to commissioners this is a two-way street. The data provides commissioners with a tool to monitor the work of providers, identify gaps which may need to be addressed (may be inhibiting progress) and ensure that their money is being used effectively and efficiently.

Analysis of TOPs data can help to predict outcomes so allowing providers, commissioners, partners and the Government to see trends both in substance misuse generally and in its

treatment outcomes as well as allowing providers to compare their own performance against the norm. Providers can also use this predictive element to encourage individual service users letting them know, for example, that if after say 6 months they are managing not to use a particular substance then they have a very strong chance of being able to sustain that in the long term.

Purpose of the Tool

From this, it is clear that the tool needed to be child friendly; something children and young people could both understand and to which they could relate. The core function of the tool is to:

- capture information concerning distance travelled for children and young people in substance misuse treatment, which would permit the Welsh Government to assess the overall performance of the sector, to identify trends and allow a strategic overview.

Ideally, the tool might also collect data to permit other uses:

- evaluation of the performance of individual providers for use by providers themselves, Area Planning Boards, commissioners and others;
- the identification of trends in substance use;
- the identification of trends in treatment effectiveness and efficiency;
- the identification of gaps in service provision (often in other sectors) which may inhibit treatment outcomes for those using substances;
- to provide base-line data against which providers can test their own performance;
- as a clinical tool to help in the treatment outcomes for individual clients and for client groups within a particular team.

Purpose of the evaluation

This report presents findings from the evaluation of Phase 1 of the pilot of the YPOMT. More specifically, the purpose of this study is to evaluate the way in which the data are being collected: to ascertain whether the form is child friendly; to ascertain whether there are any extraneous data being collected and if so what; or whether there is anything missing and if so what; whether there are problems with completing the forms and the frequency with which they need to be completed; what providers, commissioners and the Welsh Government want the forms to do and whether they are fit for purpose. The pilot and the evaluation are therefore about the Tool itself. In this evaluation we have not been asked to test whether or not the Tool is measuring outcomes. Future evaluations may study the effectiveness of the Tool at measuring outcomes and other aspects of the Tool.

Before embarking on the evaluation it is important to note that the agencies and commissioners were very supportive of the way in which they had been included

throughout the process. They felt that this inclusion would help to ensure a full and positive roll-out when the Tool is finalised.

> '*So I know that my team will already feel that they have had an involvement in the development of this tool and therefore they have had the chance to say this is what we feel would work for the young people and the children that we're working with*.' (Provider 7)

2. Methods

It was mentioned above that the principal objective of this evaluation was to examine the Young Persons' Outcome Monitoring Tool and determine whether it is fit for purpose. To achieve this goal the evaluation adopted a mixed strategy approach that involved the collection and analysis of quantitative and qualitative data. It used a variety of data sources and methods of analysis including a focus group, interviews with key stakeholders, on-line surveys of young people and professionals working in the field of substance misuse, and analyses of data collected using the Tool during the 6-month pilot period. These methods are described in more detail below.

Focus group

An important source of data for the evaluation was a focus group of key stakeholders. Focus groups are a useful and economical way of gathering data from multiple sources at the same time. They involve facilitators (in this case the two evaluators) leading discussions on key issues to elucidate opinions and generate debate from individuals. Focus groups are especially useful in that they generate a large amount of data in a short space of time, they enable researchers to target specific areas of interest and, perhaps most usefully, they provide enable participants to compare their experiences and identify areas of consensus and of diversity (Davies et al 2011). That said, focus groups are not without their limitations (e.g. the dominant participant who speaks over all others) and require careful oversight by experienced facilitators.

The focus group was held in mid-Wales (a location central to all pilot providers) at the end of the first pilot period (in early March 2016). The timing was useful in that the Tool had been in use for six months and the key strengths and weaknesses of it were well known by the participants. All of the pilot providers were invited to send representatives to the focus group and, in total, 13 people attended. There were representatives from all seven areas involved in the pilot. These included representatives from eight of the providers and from three commissioners.

Research has shown that the ideal size of a focus group is five to 10 participants but for particularly sensitive topics a smaller size of six to eight participants is recommended (Coghlan and Brydon-Miller 2014). The group of 13 participants was therefore split into two and discussions were held in separate rooms (although the two groups were brought together at regular intervals for feedback sessions). The focus groups were audio-recorded and transcribed securely and professionally by Voicescript Ltd. The transcripts were analysed thematically and the results of this analysis are presented later in this report.

Interviews

Semi-structured, telephone interviews were conducted with 12 key stakeholders from seven of the provider organisations and two commissioners. Three representatives of the Welsh Government also participated in a brief joint interview. The aim of the interviews was to investigate the views and experiences of those people who use the Tool as part of their professional role or job. Interviews are widely used in evaluation research and have many benefits. The 'structured' part of a semi-structured interview allows for comparable data to be collected across interviewees. The 'semi' part, by contrast, leaves room for interviewees to express their views in their own terms and for discussions to evolve and flow without restriction. The main limitations of semi-structured interviews are largely based on the time that they take to conduct and the large amount of data that they generate, which can sometimes be difficult and time-consuming to analyse (Bryman 2012). It was largely for resource reasons (both time and money) that the decision was taken to conduct telephone rather than face-to-face interviews.

The 13 interviewees were a combination of key workers, managers, commissioners, and representatives from Welsh Government. The interviews lasted on average, 40 minutes, and were all audi-recorded (with permission from the interviewee). The recordings were transcribed by Voicescript Ltd and the transcripts were analysed thematically in the same way as the focus group transcripts. The results are presented later in this report.

Online surveys

In addition to the focus group and interviews, two online surveys were developed using Smart Survey (a UK based survey company). One survey was designed for young people with experience of completing the Tool and the other was designed for professionals with a working knowledge of the Tool but who had not participated in the focus group or interviews. It was hoped that the surveys would complement the other methods of data collection and shed further light on use of the Tool in practice. Perhaps most importantly, the young person's survey would also provide a voice to the very people that the Tool was designed for.

Online surveys have become popular in recent years largely because they are a quick and cheap way of gaining access to potentially large numbers of informants. Online surveys can be distributed quickly and easily via email and can be completed at the participant's convenience. Online surveys can generate quantitative and qualitative data and do not require an interviewer to be present. The main limitation of online surveys is that response rates are often low, which reduces their external validity. The absence of an interviewer to clarify and probe issues with respondents is also a weakness (Bryman 2012).

The benefits of online surveys were felt to outweigh the costs and two surveys were subsequently designed. Invitations to participate were distributed to the provider organisations and to other key stakeholders. Recruitment of young people was reliant on the support of the provider organisations – for ethical reasons the evaluators were not able to recruit them directly. By the end of the evaluation period, five young people had

completed the service user survey and 10 people had completed the staff survey. The survey data were converted into an SPSS dataset and analysed using standard descriptive statistics.

Quantitative data analysis

An important part of the evaluation was the analysis of data that had been collected using the Tool during the pilot period. The main aim of this analysis was to examine the quality and quantity of the data collected and to highlight key issues (e.g. whether the Tool was generating data amenable to analysis). The aim was not to assess the validity of the Tool (i.e. its ability to measure and monitor change over time). Data from each of the pilot providers were combined into an SPSS dataset comprising more than 600 cases. The full dataset was analysed in aggregate (rather than by individual provider) using standard descriptive statistics. The quality of the data and its strengths and limitations are discussed later in the report.

Ethics

The evaluation was conducted in according with the British Society of Criminology's Code of Ethics and University regulations. Ethical approval was obtained from Aberystwyth University's Research Ethics Panel. Care was taken to ensure the welfare of all participants involved in the research. In this regard, each participant was provided with clear information (either verbally or in writing depending on the method of data collection) about the research prior to his/her participation. Particular care was taken to ensure that the online survey for young people used appropriate language and that it would not interfere in their treatment journey. This involved seeking advice from a treatment provider and getting feedback on the content and format of the questionnaire. Consent was gained in various ways depending on the method of data collection being used. Focus group participants completed hard copy consent forms; interviewees provided verbal consent over the telephone; and survey participants implied their consent by entering the survey and submitting their responses. To protect the identity of focus group participants and interviewees, code numbers were allocated that made no reference to the method of data collection. The online surveys were anonymous and the quantitative data submitted by providers had been anonymised prior to submission.

Summary

This chapter has provided an overview of the methods used in the evaluation. It has outlined the aims of the evaluation, summarised the broad strategy adopted and described and justified the methods of data collection. The following chapters move on to present the results of firstly the quantitative data analysis, secondly the two online surveys and thirdly the semi-structured interviews and focus groups. The report ends with a discussion in which the implications are discussed and suggestions for Phase 2 of the pilot are made.

3. Quantitative data analysis

This chapter presents the results of the analyses of the quantitative data collected in the 10 areas during the pilot period (September 2015 to February 2016). The purpose of this analysis is to identify any issues in the characteristics and nature of the data being collected. The analysis does not assess the validity of the Tool (i.e. its ability to measure change over time). We anticipate (and recommend) that such an assessment will be undertaken during the early stages of the use of the final tool.

Data collection

It was noted earlier in the report that hard copies of the Tool were (always) used to collect data from young people receiving support from the pilot providers and that completed Tools were usually stored in hard copy case files. Electronic versions, for submission to WG, were entered directly by workers (or managers) into Excel Workbooks comprising three separate sheets (corresponding to the three main sections of the Tool). Each Workbook covered a one month period[1]. The Excel workbooks were then submitted to staff at WG who subsequently passed on the data to the evaluators. The first batch of data, covering September to December 2015 (inclusive), was received on 28 January 2016 and general feedback on data quality issues was provided by the evaluators to WG shortly thereafter. The second batch, covering January and February 2016, was received on 30 March 2016. To the best of our knowledge, no analysis or review of the data submitted by the providers has been undertaken by WG staff.

The dataset

The data included in this analysis were extracted from 61 Excel Workbooks (each containing 3 sheets) and entered into one large SPSS database for analysis. The data covered the period from September 2015 to February 2016 (inclusive) although it should be noted December data were missing for two of the providers.

The original SPSS dataset comprised 647 cases (a case being a completed Tool). Fourteen of these cases were duplicates and 18 did not have ID numbers. One further case was excluded because it did not include any data aside from some text indicating that it had not been possible to conduct the review. These 33 cases were subsequently deleted from the dataset leaving a total of 614 cases that form the basis of the analyses presented in this chapter.

Table 3.1 below provides information about the number of cases per area/provider. Powys was the area with the most (n=105) while both Cwm Taf 1 and Cardiff/Vale of Glamorgan had the least (n=34).

[1] On one occasion data were combined across two months.

Table 3.1 Number of cases per provider

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Cardiff and Vale	34	5.5	5.5	5.5
	Cwm Taf 1	34	5.5	5.5	11.1
	Cwm Taf 2	52	8.5	8.5	19.5
	Dyfed	88	14.3	14.3	33.9
	Gwent 1	30	4.9	4.9	38.8
	Gwent 2	82	13.4	13.4	52.1
	North Wales 1	61	9.9	9.9	62.1
	North Wales 2	73	11.9	11.9	73.9
	Powys	105	17.1	17.1	91.0
	Western Bay	55	9.0	9.0	100.0
	Total	614	100.0	100.0	

Sample sizes

The figures in Table 3.2 below show that the 614 cases were in respect of 359 unique young people. The majority of these young people (59%) had completed the form just once. Just under a quarter (24%) had completed the form twice and the remainder had completed it multiple times (including 14 people who had completed it 5 or more times).

Table 3.2 Number of forms and number of unique young people

Number of forms	**Total no. of unique forms**	**% of all forms**	**Total no. of unique young people**	**% of all unique young people**
1 form only	359	59%	214	59%
2 forms only	145	24%	86	24%
3 forms only	59	10%	28	8%
4 forms only	31	5%	17	5%
5 forms only	14	2%	8	2%
6 forms only	6	1%	6	2%
TOTAL	**614**	**100%**	**359**	**100%**

Notes: Excluding duplicates (n=14), cases without ID number (n=18) and one 'empty' case (n=1).

In most cases, when only one form had been completed, this was labelled as an 'initial' assessment. However, in some cases it was labelled as a 'review' (n=89) and at other times

as an 'exit' (n=24). The labelling of cases in this way invites several questions. Is it possible for the first form to be an 'exit' form? What are the benefits of recording only 'exit' information? Could it be that these are data entry errors?

It should be noted that the date on which the Tool was completed was missing in 30 cases. In 28 of these cases (in respect of 8 individuals), data about the type of form (i.e. initial, review or exit) was also missing. Without the date and without the type of form, it is not possible to determine the temporal order in which the forms were completed. If the purpose of this analysis was to examine the validity of the Tool we would have had to exclude these cases. For the purposes of this more general analysis, however, we have retained them.

Sample characteristics

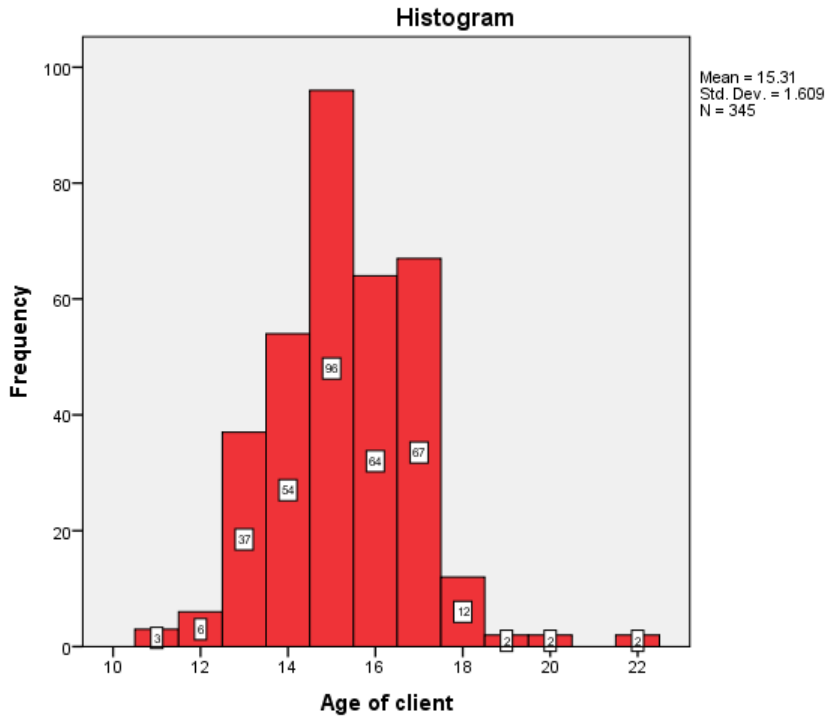
In this section we examine the characteristics of the 359 unique young people who were included in the dataset. Nearly two-thirds of the young people in this sample were male (n=226; 63%) and just over one-third (35%) were female. In eight cases (2%) the sex of the young person was not recorded.

Table 3.3 Sex of young person

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	125	34.8	34.8	34.8
	Male	226	63.0	63.0	97.8
	Missing	8	2.2	2.2	100.0
	Total	359	100.0	100.0	

Among the 345 cases where the age of the young person was recorded (14 missing cases), the mean age was 15.31 (ranging from 11 to 22, sd=1.608). Given that the Tool was designed for use among under 18s, it is interesting to note that it was completed for 18 people aged 18 or over. For the purposes of this report we have retained these older service users within the dataset. Consideration might be given as to whether this is appropriate in the future.

Figure 3.1 Age of young person



One might anticipate that a transfer to adult services would be appropriate for the older service users in the sample. In practice, however, a transfer was indicated in only four cases. Three of these were in relation to young people aged 18 or over and 1 was in respect of a 17 year old. Transfers to adult services appear to be rare events.

Method of completion

In this section (and for the remainder of the chapter) the analysis draws on the full dataset of 614 cases. Completion of the form by telephone was uncommon and reported in only 7 cases (1%). Face-to-face completion was clearly the most commonly used method (94%) (see Table 3.4). The mode of completion was not reported in 29 cases.

Table 3.4 Method of completion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Face to face	578	94.1	94.1	94.1
	Missing	29	4.7	4.7	98.9
	Telephone	7	1.1	1.1	100.0
	Total	614	100.0	100.0	

Preference for 7 or 28 day period

In Section 2 of the Tool young people were asked to indicate whether they preferred to answer questions about their use of various drugs in the last 7 days or in the last 28 days. The question was answered in 426 cases (i.e. there were 188 missing cases). In more than one-quarter of cases (28%) no preference was reported. One person commented that it depended on the type of drug being used. When a preference was reported, it was more often for the recent 7 day period than the 28 day period. In six cases the young person indicated that they did not like either of the options. All six of these cases were in respect of unique individuals.

Table 3.5 Preference for 7 or 28 day period

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	28	19	3.1	3.1	3.1
	7	232	37.8	37.8	40.9
	Both	169	27.5	27.5	68.4
	Missing	188	30.6	30.6	99.0
	Neither	6	1.0	1.0	100.0
	Total	614	100.0	100.0	

Substance use

In this section we examine the data relating to the use of various substances. For simplicity, the analysis focuses on those cases where valid answers were given. Cases where data were missing or where entries not amenable to quantitative analysis were provided have been excluded.

The data presented in Table 3.6 below shows the number of cases where young people provided information about the number of days on which they had used various substances. Information in relation to cannabis and alcohol were provided more often than any other drug type. Comparatively few cases included information about cocaine, amphetamine or opiate use.

Table 3.6 Use of specific drugs in the last 7 days and in the last 28 days

Substance	7 days	28 days
Cannabis	312	334
Alcohol	142	221
Opiates	4	4
Cocaine	12	23
Amphetamines	7	13
NPS	22	31
Other 1	36	46
Other 2	2	5

Notes: Excluding missing cases and cases where data were not amenable to quantitative analysis. In some cases, the young person provided information in relation to only one of the time periods.

The use of NPS in the last 7 days was reported in 22 cases and use in the last 28 days was reported in 31 cases. When the type of NPS was recorded, it was usually either synthetic cannabinoids or mephedrone. In many cases, however, the type of NPS was not specified. This lack of information may reflect the design of the form in which no space or dotted lines are provided for this information to be included.

The two 'other' categories were included on the form to give young people the opportunity to provide information about any other substances used in the last 7 or 28 days. The most popular 'other' drug types were tobacco and MDMA/ecstasy although a range of substances were listed. These included benzodiazepines, solvents, energy drinks, LSD, ketamine, prescribed medication and aerosols.

Quantity of drug used

In cases where young people reported use of a substance, they were asked to provide information about the quantity of the substance consumed during an 'average using day'. In many cases the guidance issued with the Tool was followed and the specified measurements were used (e.g. grams for cannabis, units for alcohol, etc). In some cases, however, the information included on the form deviated from the guidance. For example, in relation to cannabis, some cases included information on the amount of money spent while others referred to the number of spliffs, joints and 'shares' (i.e. how much was shared between a group of users). Variation was also evident in the other drug types (understandably so, in relation to 'other' drugs which naturally covered a range of different substances and hence different measures). Alcohol was the clear exception here as the concept of units was applied almost routinely.

Stability of use

Users of each substance were also asked to comment on whether or not their use of the substance had increased, decreased or stayed the same, presumably in the period since they

had last completed the Tool. In the majority of cases, appropriate answers were given. In some cases, however, alternative text was used. For example, in relation to cannabis use, answers to this question included: '*amount increased, time decreased*', '*first time*', '*increased then decreased*', '*increased (because of birthday)*', and '*one off*'. A similar pattern of responses was noted for the other drug types.

Age of first use

Users of each substance were also asked to provide information about the age at which they had first used that substance. In most cases the appropriate information was provided (i.e. a specific age was given). In some cases, however, two ages or a range of ages were given (e.g. 15/16 or 13-15) while in other cases no age was provided at all. It is not possible to give precise numbers of missing cases, but a rough estimate would be around 35 for cannabis and no more than 10 for each of the other drug types.

Injecting

Two questions on injecting were included on the Tool. The first asked whether the young person had 'ever' injected and the second asked whether the young person had injected in the last 28 days. Only two forms (in respect of two unique individuals) indicated that the young person had ever injected and none indicated that the young person had done so in the last 28 days. A small number of missing cases were again evident (no more than 20 for each question).

Health and Wellbeing

Five questions on the Tool included 11-point rating scales (from 0-10). The five questions covered issues relating to health and wellbeing and asked about life satisfaction, whether they felt that things in their lives were worthwhile, anxiety levels, happiness, and relationships with family and friends. The answers to these questions are provided in Table 3.7 below. For the most part, useful data were provided that would be suitable to monitor changes over time. However, there were a large number of missing cases, particularly for Q2 (n=28) and Q5 (n=58). Q2 asked how worthwhile the young person felt his/her life was. The missing answers here were sometimes because the young person declined to answer or would not complete it. Q5 asked young people to rate their relationships with family/friends. The missing answers here were often because the young person had provided more than one rating (e.g. one for family and one for friends; or one for Mum and another for Dad). Evidently, some young people had difficulty answering some of these questions.

Table 3.7 Questions on health and wellbeing

	0	1	2	3	4	5	6	7	8	9	10	Other/ missing	Total
Q1 - life satisfaction	6	5	17	7	41	80	68	111	116	67	79	17	614
Q2 - life worthwhile	9	5	10	22	34	88	74	113	109	47	75	28	614
Q3 - anxiety	63	18	31	27	31	58	45	50	68	31	174	18	614
Q4 - happiness	15	9	21	23	31	68	65	100	105	57	101	19	614
Q5 - family/friends	6	5	11	8	21	46	57	83	93	89	137	58	614

One further point to note about the data in Table 3.7 is the different pattern of results for Q3 which asked how anxious the young person felt today. While a score of zero for each of the five questions always reflected a negative state of wellbeing, there was an important difference in Q3. A score of zero in all other questions reflected a small amount of a positive state (e.g. not at all satisfied or not at all happy) but a score of zero on Q3 reflected a large amount of a negative state (e.g. completely anxious). This subtle but important difference has the potential to confound the results. While we cannot say that this is indeed the case, the unusually large number of zero scores for this question seems at odds with the comparatively small number of zero scores for the other questions.

Goals achieved

The last question on the Tool asks young people to think about their care plan and indicate how many of their treatment goals have been achieved. The figures in Table 3.8 present the results from this question. The majority of responses to this question conformed with the guidance given and were suitable for quantitative analysis. There were, however, a large number of missing cases (n=62). There were also 11 cases where written responses were included instead of the standard numerical answers. The written responses included comments such as: '*new referral*', '*no legal highs*', '*no NPS for 3 months*', '*up and down*', '*stopped smoking cannabis*', '*yes - significant decrease in use of NPS*'. Some of these comments may help to explain why there were 62 missing entries. For example, in the case of new referrals, it would not be possible to provide an answer to this question.

Table 3.8 What treatment goals do you think you have achieved?

None yet	Some	About half	A lot	All	Other	Missing	TOTAL
221	153	51	76	40	11	62	614

Summary

This chapter has examined the data collected by providers during the pilot period. Each question has been analysed in turn and key issues have been identified. Two particularly important points to note from this analysis are the time-consuming nature of the analysis, which was largely due to the format in which the data were submitted, and the large amount of missing data. It is understood that a more user-friendly system will be introduced when the Tool is formally launched in April 2017. Prior to its official launch this system should be piloted as should the method of data analysis and the presentation of results in a child-friendly format.

In addition to the general issues about data collection practices, the analysis also highlighted some other key issues. Of particular note was the issue concerning the date (or point in the treatment journey) on which the Tool was completed. Without some indication of temporal order it is not be possible to measure changes over time, which is of crucial importance given that the key aim of the Tool is monitoring outcomes. Also of interest is the inclusion of people aged 18 and over in the sample and the small number of transfers to adult services reported. Given that the Tool is designed for people aged 17 or less, is it appropriate to include older people in the sample? Similarly, is it appropriate to include measures of tobacco use within the Tool or to include young people who do not have a problem themselves with alcohol or drugs? It is important that the population being targeted by the Tool is clearly outlined in the future to ensure consistency across providers. With regard to the specific questions on the Tool, problems were noted with Section 3 particularly in relation to the anxiety and the relationship with family/friends questions. Some thought must therefore be given to reviewing the phrasing of these questions. Thought might also be given to the benefit of dedicating space on the Tool to questions about injecting given that so few young people in this sample had ever injected.

4. Analysis of online survey data

In this section we present findings from two online surveys that were developed as part of the evaluation. The surveys were both designed in Smart Survey (a UK based survey company) and involved respondents ticking boxes and, where appropriate, providing additional qualitative information to explain their tick box answers. The main aim of the surveys was to generate additional data from a wider sample of respondents that would complement the data collected from the interviews and focus group. It was also anticipated that the survey data would help shed light on issues highlighted in the quantitative analysis of the data collected during the pilot period. While the two surveys cover similar terrain, for clarity, the results are presented separately below.

Service user survey

To investigate the views and experiences of young people who had completed the Tool, an anonymous, online survey was developed. A link to the survey was sent to all pilot providers along with an email requesting their help in recruiting young people to take part. This approach resulted in the recruitment of five young people. While the sample is small (much smaller than we had hoped), the responses are nevertheless important not least because they provide young people with a voice in this evaluation. The results of the survey are presented below. Inevitably, given the small sample size, conclusions must be drawn with caution.

Sample characteristics

The five young people who completed the survey were all based in the South Wales area (four from Newport and one from Merthyr). All of them were White British and all four reported that English was their first language. Their ages ranged from 14 to 17 (mean of 15.6) and four of them were male. Four of the young people indicated that cannabis was the drug they had consumed most often and one reported that it was alcohol.

All five of the respondents said that they were currently receiving help for their use of cannabis. Two of them were also receiving support for use of other drugs (one for amphetamine and mephedrone use and the other for use of MSJs (i.e. street valium)). When asked about the type of support that they were currently receiving, three described this specifically as 'one-to-one support'; one explained that he was 'seeing a drugs worker' (which could perhaps also be categorised as one-to-one support); and one reported receiving 'cannabis reduction support' from an unspecified source or sources.

Completing the Tool

All of the respondents had completed the Tool more than once. Three had completed it 2-4 times, one had completed it 5-8 times and one was not sure how many times he had completed it. All of the young people reported that they completed the Tool once a month and all but one of them were happy with this frequency (the other indicated that he would like to complete it less often). In terms of the length of time that it took to complete, three said that it took 5-10 minutes and two said it took less than 5 minutes.

In all cases, the Tool was completed as part of a face-to-face session with a drug worker. One young person said that he completed the Tool himself with help from his worker while the other four helped their worker complete it on their behalf. Two young people provided details about why they needed help completing the Tool. Their responses were: '*can't be bothered to write*' and '*If there are bits I don't understand around table, i.e. opiates and NPS. Too many categories around drugs*'. The reasons were therefore related to a lack of motivation (or perhaps laziness) and to difficulties understanding the questions.

When asked how easy the Tool as a whole was to complete, the responses were mixed. Two of the young people indicated that they found it 'easy', two found it 'ok' and one indicated that they found it hard to complete. When asked whether there were any specific questions that they found hard to understand, two respondents indicated that there were and provided some further information about what it was that they found hard. One referred to '*scales not flowing*' and highlighted that '*cannabis is only recognised in grams*'. The other referred more generally to the questions '*around drug use*'. Interestingly, there were no questions that the young people did not like being asked.

To probe the young people's views on the 11-point scales in the Health and Wellbeing section, the survey included a question that asked whether the young people had difficulty deciding number on the scale to tick. Again, the answers were mixed with two indicating that they had experienced difficulties while three said that they had not. When asked whether they would prefer words instead of numbers on the scales, the sample was divided with two saying 'yes', two saying 'no' and one indicating that they were unsure.

In addition to examining the comprehension and ease of understanding of the Tool, the survey also examined the utility of the Tool for the young people themselves. The survey asked whether the Tool helped the young person to see how well he/she was doing. Three young people provided positive responses and said that it did help them. One was less positive and said that it did not help him. The remaining young person was unsure. While the findings are clearly mixed, there is some evidence to suggest that the Tool has been helpful to some young people.

Changing the Tool

As part of the survey, questions were asked about potential changes to the Tool. This included asking the young people whether they thought that issues such as offending, accommodation and finances should be included in the Tool. The results are presented in

Table 4.1 below. Of the 10 issues suggested to them, mental health was the only one that all of the young people agreed should be included. There was also agreement about what should NOT be included, namely questions about 'where you live'. All five young people were also unsure about whether or not questions on independence should be included. Views on the other seven topics were mixed. For example, two young people indicated that offending behaviour should be included, two indicated that it should not be and one was unsure.

Table 4.1 Frequency of views on the inclusion of new topics in the Tool

Potential new topics	**Yes**	**No**	**Unsure**	**Total**
Mental health	5	0	0	5
Physical health	4	0	1	5
Offending	2	2	1	5
School, training, work	2	2	1	5
Confidence	2	0	3	5
Need for money	1	3	1	5
Domestic abuse	1	1	3	5
Sexual violence	1	0	4	5
Where you live	0	5	0	5
Independence	0	0	5	5

The penultimate question in the survey asked whether the young person felt that there was anything missing from the Tool. Not one of the five young people indicated that there was. Four did not answer, perhaps indicating that they did not think that anything was missing, and one ticked 'no'. The last question gave the young people an opportunity to write anything they wanted to about the Tool. No responses were given to this question.

Summary

In this section findings from the online survey of service users were presented. While the sample is small (n=5) the results are nevertheless useful in providing the views of those who have actually completed the Tool. The findings, however, must be considered with caution given the sample size and unrepresentative nature of the sample (e.g. all five were from South Wales). All five of the young people had completed the Tool more than once and, on average, it took no more than 10 minutes to complete. The Tool was routinely completed as part of a face-to-face session with a drugs worker and more often than not, the Tool was completed by the worker with the assistance of the young person. The need for help in completing the form was linked to either a lack of motivation or difficulty in understanding the questions. Mixed views were given on the difficulty of completing the Tool and two young people indicated that there were specific questions that were hard to understand. Mixed views were also given in relation to the 11-point scales and there was no consensus of opinion on the benefits of using words rather than numbers within the scales. By contrast, there was unanimous agreement that the Tool should include questions

on mental health and that it should NOT include questions about 'where you live'. The utility of the Tool to the young people was investigated and the responses indicated that it had been helpful to at least some of the young people who had completed it.

Staff survey

The main aim of the 'staff' survey was to provide the opportunity for those who had not been interviewed or who had not taken part in the focus group, to feedback on their perceptions of the Tool and their experiences of using it. To recruit relevant respondents, a link to the survey was emailed to all pilot providers (and to commissioners in the pilot areas) along with an email outlining the aims of the survey and a request to participate. As before, the response rate was not as good as we had hoped (n=10). Nevertheless, the results do provide some additional information that is useful for the evaluation. The findings are presented below but, again, caution must be taken when drawing conclusions given the small sample size.

Sample characteristics

The sample was mixed in terms of gender - six of the respondents were female and four were male. Most of the respondents (n=7) were key workers, two were managers and one described himself as a '*specialist*'. All of the respondents had experience of supporting children and young people with substance misuse problems and the majority (n=7) had been doing this for more than three years. In fact, four respondents had been working in this capacity for 10 or more years. All of the respondents indicated that they were supporting multiple young people at the time of completing the questionnaire. Most (n=7) were supporting less than 10 young people but three were supporting more than 10 (including one worker who said that he was supporting 56 young people).

Use of the Tool

All but one of the respondents had extensive experience of using the Tool. Eight respondents had used the Tool on 10 or more occasions, one had used it 6-9 times and one had used it just once. When asked whether they had received any guidance or training on how to use the Tool, all but one indicated that they had. The type of guidance provided was described as written guidance and/or guidance provided (presumably orally) in team meetings or directly from line managers. Four respondents reported receiving both written and oral guidance while the remainder referred only to written guidance (n=2) or only to oral guidance (n=3). Most respondents felt that the guidance given was at least somewhat helpful. In fact, five indicated that it was either very or extremely helpful. Only one respondent indicated that the guidance was 'not at all helpful'.

Aims of the Tool

Respondents were asked to write in their own words what they thought was the main aim of the Tool. The responses from each of the 10 respondents are presented in Table 4.2 below. Most of the respondents thought the Tool's main aim was to monitor progress made by the young person and one specifically referred to the Tool as the '*TOP equivalent for young people*'. Others were less specific and referred more generally to the Tool as a source of data or information.

When asked whether they thought that the Tool achieved its aim, six respondents indicated that it did, three were unsure and one indicated that it did not. Those who unsure or did not think the aims had been achieved were asked to explain their thoughts on this. Three responses were provided. One accepted that the Tool gathered information but highlighted the fact that there were differing views about its purpose. Another respondent felt that it was unclear why certain questions were included on the Tool and the other indicated that some questions needed to be worded differently or even removed.

Table 4.2 Staff views on the main aims of the Tool

Respondent	**What do you think is the main aim of the Tool?**
1	To gather information
2	A tick box exercise for the gathering of stats
3	Aim is to monitor the young person's substance use and other factors which can influence the young person to use, such as how things are going in their life.
4	Measure distance travelled whilst in services
5	To assess and monitor the young person, with the aims to be able to track progression -/+ around there moods and substance use/misuse.
6	To gather info on links between mood and YP drug use
7	To identify outcomes and potential distance travelled
8	To monitor the progress of the young people.
9	To provide proof of outcomes and to show progress.
10	TOP equivalent for young people. - Monitors individual but also provides an overview of those accessing treatment within Wales.

Respondents were also asked for their thoughts on whether the Tool fully captured the treatment journey travelled by the young person. Only one person felt that it did. The remainder were either unsure (n=4) or thought that it did not (n=5). Those who responded less than positively to this question were asked to explain what more they would like the Tool to do. Four interesting responses were provided all covering slightly different issues. One respondent referred to the need for '*a more YP friendly form with relevant questions*'. Another highlighted the fact that it '*can depend on the day on which it is completed*' and warned that it '*may not always be truly representative of an overall journey*'. A third indicated that '*it doesn't capture emotional and/or social progress*' and the fourth wrote that there was '*no option to discuss/measure therapeutic alliance*'.

When asked what would better achieve the aims of the Tool, respondents described things related to the purpose and content of the Tool as well as to the recording of the data collected using it. One described the need for a form that staff and young people could both see the benefit in completing. Two respondents described the need for different, more appropriately worded questions, and one referred to the need for better electronic recording systems. One further respondent was a little more positive and indicated that with some '*minor adjustment*' the tool would be '*on track*.

Completing the Tool

The respondents indicated that their individual organisations were currently supporting, on average, 28 young people to deal with substance misuse problems (standard deviation 18.7 years, range = 10-56). When asked how many young people, to the best of their knowledge, in their organisation had completed the Tool, eight provided valid responses (two were unsure). Five thought that the Tool had been completed 30 or more times (including one who wrote '*approx. 70*') and three thought it had been completed less than 20 times.

Respondents were asked to provide details of the number of young people who they had helped to complete initial, review and exit forms during the pilot period. The results are presented in Table 4.3 below. All eight of the respondents who answered this question had helped at least one young person complete an initial form and five of these had helped more than 10 young people do this. As might be expected, Reviews and Exits were less frequently reported although three respondents had been involved in multiple reviews and one had been involved in multiple exits.

Table 4.3 Number of initial, review and exit Tools completed

Number of young people	**Initial**	**Review**	**Exit**
0	0	1	1
1-10	3	4	6
10+	5	3	1
Total	8	8	8

Notes: 2 missing cases.

When asked about the proportion of young people that needed help completing the Tool, all of those who answered the question (n=9) indicated that the majority of young people needed help. Two indicated that it was between 75-99% of young people and a further seven said that 'all' young people needed help with it. The language used in the Tool was reported by six respondents as the main reason why help was needed. One of these described the wording as '*extremely adult*' and another referred to it as '*very wordy and not YP friendly*'. Other reasons included: '*substance misuse is a problem but not the primary issue for all of*

them', '*I complete the forms verbally to the young people and record their answers myself*', '*support with their own substance use issues and/or with familial substance misuse issues*'.

Perceptions of the Tool

The data in Table 4.4 relate to staff perceptions about the questions on the Tool. The majority (n=9) of respondents felt that there were questions that young people found difficult to understand. When probed to list which questions were problematic, most (n=8) respondents listed one or more questions from Section 3 of the Tool (i.e. the section on Health and Wellbeing). Three respondents indicated that the question asking 'To what extent do you feel that things you do in your life are worthwhile' was difficult to understand, but they did not elaborate on the reasons why. Three respondents felt that the question on anxiety levels was difficult for young people to understand. One of these respondents explained that this was because they had to '*explain what anxiety/what anxious means*'. Two referred to the question on relationships with family/friends. Both of these respondents thought that the question should be separated into two as '*there is often a difference in the relationships with the two groups*'. One respondent focused on the happiness question and asked '*why would I ask them how happy they were yesterday*?' The question on overall life satisfaction was also mentioned by one respondent without any further elaboration.

While the focus of concern was mainly on Section 3, reference was also made to the 28 day questions in the drug section of the Tool. Two respondents highlighted this as a problem and one indicated that the difficulty was related to memory, '*Remembering the substances they took 28 days ago'*.

Table 4.4 Numbers reporting difficulties with the questions

Difficulties with the questions	**Yes**	**No**	**I'm not sure**	**Total**
Any questions difficult to understand?	9	1	0	10
Any questions you feel uncomfortable asking?	2	7	1	10
Any questions the YP do not like to be asked?	5	5	0	10

The questionnaire also asked staff whether there were any questions that they felt uncomfortable asking. Two respondents indicated that there were. When asked to elaborate, four responses were obtained. One highlighted the injecting question and explained that this was because it can '*engender defensiveness'*. Two respondents referred to the questions on life satisfaction and things being worthwhile. One commented that the reason for discomfort was '*because the young people tend to focus on the negative rather than the positive aspects of their lives'*. Interestingly, one respondent elaborated in more positive terms focusing on the benefits of not including certain questions that might affect rapport.

I do feel very uncomfortable asking the criminal justice questions on the TOP and so feel it is a huge positive that I no longer have to. In an open access service, it could create a lot of suspicion by the service user and have a negative impact on the established rapport.

When asked whether there were any questions that they thought the young people did not like to be asked, five thought that there were. The questions believed to be problematic were again those from Section 3 on Health and Wellbeing, although the injecting and 28 day questions were also mentioned too. These views are particularly interesting given that the young people who completed the service user survey all indicated that there were no questions that they did not like to be asked.

Use of scales

Focusing on Section 3 of the Tool, respondents were asked to state whether they thought young people found it difficult to decide which number on the 11-point scale to tick. Three respondents felt that the young people found it hard to decide. However, five thought that they did not and three were unsure. When asked to describe the difficulties experienced, the responses were fairly general although one emphasised that it was particularly hard for young people with learning difficulties. The main point made was that some young people found it '*very difficult'* and that it needed '*explaining every time'*. One referred to it as '*a frustrating system'*. Interestingly, one respondent described the subsequent impact of the difficulty: '*Some questions seem pointless to YP. If a YP is struggling to decide on a number they tend to tick the middle'*.

When asked whether a 5-point scale with words as well as numbers would help young people, eight respondents indicated that, potentially, it could. One thought that the use of emojis might help and another emphasised that the language needed to be more young-person focused. Two respondents did not think that such a change would help young people.

Completing the Tool

The survey asked respondents several questions about the way in which they usually completed the Tool with young people. Most completed it as part of a session (although two saved it to the end of the session) and all but one completed it face-to-face with the young person. On average, the Tool took no more than 10 minutes to complete (for four people it usually took less than 5 minutes). Views on the frequency of completion of the Tool were mixed. Five were content with the frequency, three thought it should be less frequent and two thought it should be completed more frequently.

In most cases (n=6), the Tool was completed without reference to the answers given on earlier occasions. When asked whether they thought having previous answers in front of them would be helpful, six thought that it would be but three were less positive (one did

not answer). One reason for not referring to previous answers was that it was '*not always pragmatic in terms of carrying around confidential information'*. Another was unsure because in his/her experience some young people '*just randomly circle and complete to get done!'*. Reference to previous answers would have little effect in such cases. One respondent commented that it would be '*probably only beneficial if things are going well'*.

Data collection and analysis

One question on the survey asked respondents to describe what they thought happened to the data after it had been entered into the Tool. Nine respondents provided answers to this. One person indicated that they had '*no idea'* but most were aware that the data were collated and sent off to commissioners. Interestingly, only one specifically mentioned that the data were submitted to Welsh Government.

When asked what they would like to be done with the data, three of the four respondents to this question referred to measurement of either the treatment journey, progress being made or distance travelled. One of these also thought that it could be used '*to measure the effectiveness of the treatment/intervention'*. The fourth respondent thought that it would be useful '*to make graphs for clients who have a more visual style to learning*'.

Utility of the Tool

Respondents were asked whether they thought that the Tool had been helpful. The majority indicated that it had been at least somewhat helpful (two thought it had been 'very helpful). However, two indicated that it had been 'not at all helpful'. When asked whether the Tool was more helpful with certain groups than others, three were unsure, four thought that it was not and three indicated that it was. These latter three respondents provided further information about the groups that they felt the Tool was most helpful with: '*more recreational and problematic mis-users'*, '*older teenagers [who] find filling in the Tool easier due to the wording'*, and '*those who use substances rather than those who are being supported with familial substance misuse issues*'.

When asked whether they thought the Tool was more useful at a particular point in a young person's treatment journey, two respondents indicated that 'yes' it was. Interesting, one of these thought it was more useful at the start and the other at the end of the journey. The other respondents were either unsure (n=4) or did not think that it was more useful at a particular point in time than another.

Use of other tools

Six respondents reported that they also used other tools when supporting young people with substance misuse problems including: internal tools and assessments, ITEP maps, ORS/SRS (outcome rating scale and session rating scale) and Care plan. Feedback on the ORS/SRS was particularly positive with comments such as '*it is concise and gives us feedback as workers'*, '*they are real time and give a good sense of how things are right here and now. Also includes*

the relationship between worker and service user' and *'I can monitor if there is increase/decrease as we travel along with the young person'.*
Substances included in the Tool

When asked whether the Tool adequately assessed all substances, six respondents indicated that it did. However, two were unsure and two thought that it did not. Those respondents who did not think so were asked to say what else they would like to see on the Tool. Both responses related to use of NPS and the need for more specific categories on the Tool (e.g. mephedrone, or type of NPS such as stimulant, depressant, powder, tablet, vapour, etc.).

A similar pattern of responses was reported in relation to the injecting question. Five respondents thought that the Tool adequately assessed injecting behaviour, two were unsure and three thought that it did not. When asked what else they would like to see in relation to injecting, one wanted it to include more about naloxone, another wanted information about patterns of injecting and the third was interested in details on the frequency of injecting.

Changing the Tool

Respondents were asked whether they would add any more questions to the Tool if they had the opportunity to do so. Three said that 'yes' they would. When asked what questions they would like to include, one referred to questions on physical health, another to use of and knowledge about harm reduction measures and the other to questions about the social context in which young people use drugs (i.e. where they use, who they use with, sources, etc.).

Four respondents indicated that, given the opportunity, they would delete questions from the Tool. All four commented that the questions that they would delete would be those in Section 3 on Health and Wellbeing. Questions specifically mentioned were those investigating happiness, life satisfaction, and the question that asked the extent to which they feel that the things they do in life are worthwhile.

As part of the survey, respondents were given a list of topics and asked to state whether or not they thought each should be included in the Tool. The results are presented in Table 4.5 below. In line with the results of the service user survey, the topic with most support was that of mental health. Physical health was once again the second most popular topic. By contrast with the service user survey, however, education, training and employment issues along with offending and accommodation had support from at least half of the sample of staff members. Evidently, staff and service users do not see wholly eye-to-eye on what topics should be included in the Tool.

Table 4.5 Staff views on the inclusion of new topics in the Tool

Potential new topics	**Yes**	**No**	**Unsure/ missing**	**Total**
Mental health	7	1	2	10
Physical health	6	3	1	10
Education, training, employment	6	2	2	10
Offending	5	4	1	10
Accommodation	5	3	2	10
Financial issues	3	5	2	10
Independence	3	2	5	10
Confidence	2	2	6	10
Domestic abuse	2	4	4	10
Sexual violence	2	4	4	10

The final question gave staff the opportunity to provide any additional comments about the Tool. No responses were provided here, which might suggest that the survey had covered all of the key issues.

Summary

In this section findings from the online staff survey were presented. The sample comprised seven key workers, two managers and one self-defined 'specialist'. All ten had a good working knowledge of and/or experience of using the Tool and all had received guidance on the Tool which most, but not all, found helpful. The majority of respondents believed that the main aim of the Tool was to monitor progress of young people in substance misuse treatment, although some respondents were vaguer than others about this. There were mixed views on whether the Tool was achieving its aims and few thought that the Tool was fully capturing the treatment journey. In the majority of cases the young person needed help completing the Tool largely due to difficulties in understanding the language used. The questions in Section 3 of the Tool (on health and wellbeing) were of particular concern and many of the respondents said that they would delete them if given the opportunity to do so. Generally speaking, the respondents found that the Tool was helpful although some were less convinced about this than others. In fact, some respondents indicated that they used other, more helpful, tools when working with young people. Of particular note is the ORS/SRS which was viewed positively by several respondents. Finally, respondents were in unanimous agreement that the Tool should include questions relating to mental health and there was a general consensus that physical health should also feature too.

5. Qualitative data analysis

This section presents findings from the analysis of qualitative research data collected by means of focus groups and semi-structured interviews. The focus group and interviews targeted providers, commissioners and policy makers to ascertain their views on the Tool. This data adds depth and texture to the quantitative data, often throwing light on how or why aspects of the Tool are found to be useful or problematic. This data therefore permits the research to explain important aspects of the use of the Tool. With qualitative data it is always important to collect as broad a spectrum of experiences and views as possible. Therefore, before attending the focus group, participants were asked to ascertain the views of both other workers in their organisation who were using the tool and, if possible, of service users. Similarly, the interviews invited participants to present their own experience and views as well as their understanding of the views of colleagues and service users. The qualitative data are therefore robust and one can be confident that its important findings have validity. The chapter is divided into four key parts that investigate: the function of the Tool; use of the data; the form and its contents; and suggested changes and additions.

The function of the Tool: Welsh Government

The Welsh Government were very clear that their only real concern was that the Tool provided them with the data necessary to allow a strategic overview of substance use and the effectiveness of interventions for children and young people.

> '*.... to measure distance travelled of that person from the first time they [children and young people] start treatment until obviously they left treatment. We would then use that data to assess performance of the sector in general so it would not be our intention to look at individual providers but to look at a strategic overview.*' (WG 1)

Furthermore, it was clear that in designing the draft tool the WG avoided the inclusion of data they considered unnecessary to this core aim. They explicitly wanted to protect both agencies and young people from having to provide extraneous data.

> '*It is the emphasis around the impact of substance misuse treatment .... separating out very important outcomes for YP in their entirety and to look at the distance travelled for the treatment specifically and being able to put a demarcation around that pragmatically I think because we could look at a number of outcomes but we wanted to ensure that the end tool was not burdensome for agencies or the young people themselves.*' (WG2)

> '*We don't want to have a tool that is collecting data that we do nothing with there is no need for that ... although agencies may wish the Tool to capture some data this isn't any kind of tool to be used for case management and they need other systems in place to be able to capture that information other than through this process*' (WG3)

However, they accepted that if agencies supported a broader tool only part of which would be reported on the WG site they would not prevent its design. The bottom-line was that the WG wanted the Tool to collect the information necessary to their national databases and if it collected any more than that they wanted to ensure that this extra did not involve the WG in any extra expenditure.

> '*Provided the case management systems can develop those two levels then it wouldn't be problematic because obviously all agencies collect much more data than we would require them to collect through the national databases and particularly within substance misuse because there are a number of agencies that get funding sources from different sources. ..... The national database is effectively the mechanism with the minimum data standards we would expect that all agencies comply and that is not just within the outcomes tools but across the treatment episodes so that is the element the WG would support and anything in addition to that would be for each providers' case management system.*' (WG2)

> '*Provided it was something that wasn't burdensome for them and we got the information we needed from providers then there is not an issue with that.*' (WG1)

> '*We would not want to meet the costs of any development needed to make that happen. Well we wouldn't have the funding available to do that*' (WG3)

The function of the Tool: Providers and Commissioners

Our research threw up disparate uses of the Tool. Providers and commissioners wanted to collect and use information to achieve different ends. Many of the uses they suggest reflect those which are achieved for adults through use of TOP.

Recording the journey

All the participants considered that the Tool should record the journey of the young person through treatment. They also all considered that it should have relevance for each child, be a clinical tool and part of their treatment.

> '*… for the young person as well it's good for them to look at progress made as well because I've used it to reflect back on the past say three months for example and look at patterns that have come out and may have changed. So it's quite useful from that perspective as well as from a commissioners' and Welsh Government perspective as well.'* (Provider 13)

> '*It's what does it does for them and that's what young people want to know. Does it make the intervention different, better, worse?'* (Provider 8)

> '*Because young people will flit from doing incredibly well, and then something within their adolescence phase, for example, may pop up and then knock them back. ... with any kind of treatment measuring tool, it doesn't reflect the whole picture of what may be going on with that individual at that given time... I can see that it would be beneficial but then maybe not highlight or*

give you the opportunity to maybe explain what is going on at that particular time and why that treatment has maybe not looked as successful as it should have.

'*...something around improvement or not over time is useful as well because I guess when you complete the form it gives you a snapshot of how that young person is feeling at the time. But filling that form out again in say three months time would then give you some sort of idea of improvement over time or not, which would be useful as well .... the more regular you can do it, the better it is because you can then start to build a picture of that journey. We're trying to measure an actual outcome for that young person. ... How well the young person is doing in relation to their...kind of in relation to their substance misuse but it could potentially be broader than that still. It could be as general as how well are they doing. I think that's what we're trying to measure ... substance misuse can be just one issue or the reason of use can be based on a myriad of other underlying reasons. That presenting reason is a misuse of, say, cannabis or alcohol, but there could be a lot of other things going on behind that. .. So I think although reducing or stopping the substance misuse is important, I think, especially with young people, you've got to address the other issues that could be potentially going on in their life that go hand in hand with substance misuse often, not all the time but very often it seems to. So I think the health and the wellbeing questions are important and measuring outcomes based on those are important.'* (Commissioner 1)

'*So all I've done is taken distance travelled evaluation that showed a forward movement, so I've taken that stat every quarter, I've taken showed no movement or stayed the same ... and backward movement, and it's been good to be able to show then an overall representation of individuals. ... that month things might have gone crazy and everyone starts using again, that potentially could show then to our funders ... but there's no narrative there to be able to explain it, but I thought I'd put it in anyway, be realistic. ... I think it's stripping the flesh off the bones and getting that information which is needed, I think. I think quite a lot of the work that we do is very fluffy and it's really hard to get that raw data which is good for funders.'* (Provider 17)

<u>*Designed for children and young people to support their treatment*</u>

All providers supported the clinical use of this data in supporting the child's treatment pathway. They saw the most important aspect of this information to be allowing the young person to see their own journey, to understand their own journey.

'*… you can look at that and say well actually that's changed since last time, and you can map them and use them from the previous one to the next one so we actually really can help that young person as part of their treatment, so it doesn't just become this is a form we need to fill in for Welsh Government. You kind of undermine the work you are trying to do with the young person then.'* (Provider 8)

'*So if you had the original initial in the file and then you would do a review and you could look at the past three months for example, I'd use it then with the young person, just to sort of look at any changes or how things have gone.'* (Provider 6)

'I'd look at it as part of our file audit during supervision.' (Provider 10)

'*... it shows the young person when they initially presented at the project, and what their drug use was like maybe at that point, and how they were scoring themselves with their thoughts about their life. Then by the exit phase the hope is that some of those numbers would have increased up the scale. Not always, realistically it's not always going to be like that, it's not always going to be a positive outcome, but it is a useful tool in that respect.'* (Provider 14)

Both Commissioners and Providers wanted the Tool to be young people friendly.

'so this was an opportunity to look at something that not only captured the younger cohort but might have been more appropriate to the young people as well. … a tool that's more appropriate and specific to being used with children and young people in a way that is more user-friendly for them.' (Provider 3)

Feedback needs to be child friendly to support the treatment

Others wanted feedback data from WG to be child and young person friendly so that they can show children what the data will be used for and how important their input will be. This should boost the young people, make them feel more listened to and invested in and permit them to understand that the interventions they are enjoying are part of a larger project which helps many children all over Wales. Having feedback which would relate to children might also help to encourage them to participate, recognise the worth of completing the Tool. This is part of the value of this data. With the advanced technology available today there are some really great ways of presenting results in user friendly, young person friendly way.

'Do you know what would be really lovely, is something that's young person friendly so we can feed it back to them.' (Provider 9)

'And we've changed this because we've got this information from you,' (Commissioner 5)

'*We take pains to explain to the young person what it's about and what we feel it's about but that doesn't always reassure them. Some young people are quite wary of what the information is being used for.'* (Provider 12)

'*I was struggling with a young person that was using substances, she was referred to me via a residential home and was very much I'll see a drugs worker just to shut the people up in the house, so they will get off my case.... she didn't want to talk through her drug use, and I was like right okay this is going to be a bit difficult then seeing as I am a drugs worker. But we started off with the tool and initially there was a reluctance to engage in how much she had been using, and then about four weeks into the session we were doing a review, and it was the first time that she'd actually been open and honest to anybody about her drug use, and that was using this tool. She herself said I am actually quite shocked at how much I've told you. But we used that as a baseline to start, and I had been really struggling how to get round to talking about the substances, so the tool actually worked really well in that scenario to gain that information.'* (Provider 14)

'*So it's looking at the patterns of behaviour, patterns of substance misuse for young people to be able to look at it and be able to visualise something. ... We've kind of adapted it, which may be going off-piste, to be able to create a timeline to show where things are good, where things are bad, how people have coped. So it's a yardstick of being able to see progress, times when maybe things haven't been too good, but to then unpick that and the reasons for this choice of behaviour, and then whatever the outcome from that was because of this, to look and be more reflective of their use.*' (Provider 17)

Feedback is important in order to engage the workers and providers

In order to ensure that the tool is used by all providers and all workers it needs to feed something back into the organisation and thus each worker can see the value of the tool for their work.

'*If the provider doesn't believe in the importance of the information they're collecting, then the young person probably isn't going to either. So again it's going to impact on the meaningfulness of the data that is being collected because they're just going through the exercise. ... no one has really taken ownership or is properly engaging with the form.*' (Commissioner 1)

'*… it can be very difficult to evidence what we do as effective, and I think this tool is trying to give some meaning to what we try to achieve with a young person. ... having worked in youth service, it was really hard to measure some of those soft outcomes and we were always questioned as to how we could evidence that what we were doing worked with that young person.*' (Provider 14)

Trends

Many recognised the value of looking for trends in the data. They suggested that the Welsh Government would be taking a broad overview of data collected over time and looking for trends.

'*I guess trends with the different types of drugs so trends*' (Provider 10)

'*I think the trends of what substances young are using is crucial really for them to gain insight. Because it does change, it changes significantly and I think we need to be flagging up to Welsh Government what is happening for us workers. Because our work has really changed over the last ten years. ... and I think in Wales we are way ahead of the game with regards to gathering that evidence. So there are positive things going on but that is a key thing that the Welsh Government needs to be mindful of.*' (Provider 14)

'*The trends of what's being used I think is important, because then they know what to target and what services maybe they need putting in place. Also the different things that young people go through, I think we expect sometimes our young people to put up with so much, and expect them to be more robust than they can be, and some of them just don't have the coping mechanisms. I think sometimes that's forgotten, that they are actually just children, and some of them don't have the support. I think it would be good for the government to recognise what they are going through,*

and there are a lot of young people that come through the service that could benefit from a lot of services that are being cut, or not around anymore, and actually they need them.' (Provider 16)

Monitoring

One of the commissioners' core concerns was results based accountability (RBA). Commissioners want to monitor performance, ensure that their providers deliver value for money and assess whether anyone is better off. Generally commissioners were reasonably satisfied with the draft tool, they were especially pleased that it included both soft and hard outcomes and that it reflected the voice of the service user, something which is often not captured in other assessments that they conduct.

'*I think the thing that sells it for me is that availability of a consistent tool being used by all organisations and being able to do comparisons with other services and look at themes that are arising, that kind of thing.*' (Commissioner 4)

My understanding is that it's used as a monitoring element to monitor the progress of someone that comes into treatment. So at the beginning they have their treatment and see if there's been any change as they go through. From a commissioning point of view it helps us look at what we are getting for our money so to speak. …. I think it's good that it's consistent in terms of performance monitoring and the fact that everyone is using a standardised tool and an endorsed tool means you can compare performance across regions to see if there's any pockets of areas where young people are more affected by substance misuse. Or in terms of what your services are delivering to meet need. So I quite like that.' (Commissioner 5)

Learning from Each other

Many providers were very interested in learning from each other though thought this was more important across the 'soft' outcomes such as health, happiness and wellbeing rather than the rate of substance misuse.

'*… if you're telling me that all of the individuals that you're working with are actually reporting that they're a heck of a lot happier after they've seen your service, that interests me because I want to know why they're happier and are ours that happy and is there anything that we could share in order to look at are you working better than we're working and how can we learn from that? …. Also, I suppose to capture the best practice that's out there, not to look at being competitive with each other but to look at the professionalism and the achievements of the field in a wider sense.*' (Provider 7)

Changing the provision

A number (particularly commissioners) wanted the Tool to be able to pin-point gaps in provision. However, if the Tool is to be used in this way there was a general consensus (especially amongst providers) it is important that providers are not held accountable for other services.

> '*With the information that will be coming out it will be good to see if there are certain needs or things that we are missing currently. So it will help us be more informed and change resources if need be, or focus resources on different things.'* (Commissioner 5)

> '*… not being held accountable to those but using those I suppose maybe to inform the field. Are we looking at a five year data gathering here around what additional value do substance misuse services provide other than specific substance misuse work.*' (Provider 7)

> '*… it is more so about learning from others around the health and wellbeing element, and seeing if a service is doing particularly well around that area and linking that to some of the specific substances that are being used.*' (Commissioner 4)

Professional recognition for substance misuse work

Through the collection of a reasonably broad set of data, providers were pleased that the Tool might help to support their sector in achieving the professional recognition some felt it needed and which was not always afforded by other sectors:

> '*I think for me, personally, what you were saying about being able to get staff on board in order to use a tool that is seen as valid, that's seen as reliable, that doesn't just provide data that sits on a shelf, that provides data that can really inform the substance misuse field because we're not a formal profession. So you can look at a social work profession, you can look at a teaching profession, substance misuse isn't yet a profession it its own right and, for me, there's a lot to be done at that higher strategic level to be able to get us more to that position. A tool like this would be able to join us all up more, give us a more united approach, view and understanding of what do our substance misuse services look like across Wales? What do they achieve across Wales? What do we need them to achieve? What do we want them to look like?*' (Provider 8)

One Tool for everything

Providers stated that would very much welcome one tool, one set of data that would provide the information needed for their own organisation, for their commissioners and for the WG. They clearly shared data within their organisations and used it to discuss the young person's care both with that young person and with other key workers or managers in their organisation. They also share this type of data with their commissioners and with Welsh Government. They were interested in the Tool being of active use across all these aspects of their work.

'*From an individual provider point view, wouldn't it be amazing if actually you had one set of reporting that worked for you, your commissioners and Welsh Government? .... So I guess I'd like to see something that doesn't duplicate or replicate but also, I think like you said, to be able to capture some of those wider things that we've got a contributory relationship to.*' (Provider 7)

'*From speaking to our providers, what they wanted from a tool was something that they could use as well in a therapeutic sense to monitor progress not just as a tool that is getting submitted to us, something that's of value.*' (Provider 1)

'*We might not be using all this data to churn out lots from our particular service but we are using it in the one to ones as part of their support and the young people they're working with to monitor their progress. I think that's where the biggest value should really sit, shouldn't it? .... it's not about another tool, something else you already pull in from elsewhere because you also, not only for the young people you're working with, but the staff as well, you lose a part of their buy-in and their willingness to deliver something. You think I've captured this in four different places already…in slightly different wording but essentially the same information.*' (Provider 6)

Some providers and commissioners wanted the KPIs and other performance indicators to be shaped to fit the information collected on these forms so that it would be just one collection of data. They considered it to be important for WG to have this 'joined up thinking' to link outcome data to the KPIs. Others, whilst understanding the convenience of a single collection of data considered that these were different from KPIs and could see the logic in keeping the two separate.

'*… it would be good, from my point of view, that these would be reflected in NKPIs, so it saves any additional collecting of information, it's just these ... as opposed to another form and loads and loads of things, because it would be good to have that consistency all the way through. ..... whatever the agreed form is and for that to be then escalated up, and then the indicators for these, for the children and young people's services, for it to be then moulded around these, so nothing additional will be... collected ... then the Welsh Government can extract from that any NKPIs they want to because this has all been agreed from the bottom up. I think it will be nicely married.*' (Provider 1)

'I think they are trying to defend providers and saying that if Welsh Government want KPIs they should draw it from whatever data comes out, or information that's from this form. As opposed to saying we are setting this KPI now go and collect this data to meet the KPI.' (Provider 13)

'*I think this form can avoid duplication .... because I think we set the performance indicators and I know a lot of these would make our lives and the providers' lives easier if we were both singing from the same hymn sheet, so to speak, and a lot of these outcomes we can get from this tool. Why recreate the wheel if it's already been captured? Somebody touched upon it, I don't know what it was, but if the data's already been asked and already been captured then why can we not use that data effectively, rather than like you said it sitting on a shelf. Or we take a proportion and then the rest of it gets discarded. I don't see why we couldn't just dovetail into this in terms of the local indicators and forms.'* (Commissioner 5)

'*So then you've got a Welsh Government view on what they'd like to collect, obviously the commissioning of services is going to reflect what Welsh Government want to happen in each area, and then the individual services are going to reflect what the commission service leads would like, so everything ties up like that.*' (Provider 7)

'*I think the reality is a lot of these individuals will be open to other services and that will also impact on what they're getting from the service, how they're feeling, presenting and stuff, and that's why I think it is important to have these to coincide with local performance measures because that's when you get the true picture of someone who is joint worked, somebody who has got tenancy support issues or whatever it may be. So I think as great as it would be to standardise these, I think it is important that they exist in addition to other local indicators so you get that full picture...*' (Provider 2)

'*…the tool is something that's used to make life easier, isn't it, or something like that. It's a tool. ... but just to be aware that if we are talking about KPIs and certain outcome data that we want to gather, to have that included in the form from the offset so that key workers aren't getting used to this form and then they have to create another form for various other reasons to get more data. Just try and make this as all encompassing as possible so that it ticks the boxes for everyone that's involved in using it, right up from the young person, right up to Welsh Government.'* (Commissioner 1)

This is the most important Tool that collects data concerning outcomes and therefore there might be a logic for any outcome based KPIs to be able to be evidenced from this data.

'*...it's not about processes is it, it's not about we've done this, we've done that, we can find that, it's about what's the point of it all, basically what is the outcome of that..'* (Provider 11)

The providers and commissioners considered that all the information should be uploaded onto the WG database in the same way as similar information is uploaded from TOPs.

'*... I'd see all of this being uploaded in the same way that the TOPs information is uploaded at the minute. I think Welsh Government were quite clear in the initial meetings that we had that we don't want to be collecting loads of stuff that we're not going to use. But actually, I think if we're looking at a married up approach rather than just a top down approach, if we're looking at bottom-up as well then there may well be some information in there that is literally for their information. They may choose to look at some trends and not particularly have much interest in it, but then three years later when there's quite a wealth of information about this bit, they might start to be more interested in that.*' (Provider 7)

This suggestion of a broad (though carefully controlled) collection of data and the request that both WG and Commissioners be willing to rely on this data (along with other automatic collections of data such as MRIS) for as many of their purposes arose due to the desire to protect front-line workers and providers from wasting too much time on form filling and data collection for use by government and commissioners rather than for the care of their service users. Through one form they wanted to capture what they need for the young people, their organisation, commissioners and Welsh Government. They would like to encapsulate that all in one form, not to make it extensive but to prevent having to do lots of other form filling. The Welsh Government may not be interested in parts of this information but they could provide the platform on which this information would lie. The

Welsh Government might not be interrogating all of it but the organisations themselves and commissioners might use the information. They would all have access to the data relevant to them to analyse as they pleased. It may be that in the future the WG uses data they presently are not so keen on collecting. The importance of this is to save time and ensure front line workers are free to support their clients. Everyone recognises that both workers and the children and young people get form-filling fatigue. Having one form would free-up workers to spend more time supporting children and young people. The call here is therefore not for a long form but rather to ask both WG and commissioners to design their data needs around what is collected already (on this form) rather than placing greater data collection expectations on young people, their workers and the organisations providing these services.

To be of use consistency is important

Whatever use is to be made of the data many of those we spoke to felt that consistency was important.

> *'I think it's got to be accurate for a start I guess. You want to have data that is accurate and also consistent as well. I think the problems come when a form is given out as it is in its current state, for example, and then you get maybe minimal or no guidance around that. ... I mean there's one comment that someone said, we do it in the last five minutes, we just rush through it. Whereas compared to someone else, they might spend half an hour on it. But from the spreadsheet when you see the data, you don't get that story, you just see the numbers as they are but there's quite a large inconsistency in how that data is being collected, which then makes the data a lot less meaningful because there's that inconsistency in there.'* (Commissioner 1)

In the research some people left the child to complete the form, others helped the child, others completed it but asked the child each of the questions and finally some had a general conversation and then completed the form from the information gained during that discussion. Whilst each of these methods is valid, if different processes of collection are to occur that should be noted on the form.

> **'…** *a box to say who has filled out this form. There is even an option I guess to give the form to the young person to fill out in their own time but as long as you're flagging up clearly within the data who has completed the form...I guess that's what we were talking about earlier about some of the context behind the data really. You don't want the whole story but who has completed the form, was it during a one to one session or was it the young person on their own or that sort of thing, or almost a comment box just to give a little bit of description around the context of when the form was filled in. Was it a 10 minute thing attached at the end or was the whole session focused around filling out the tool, something like that might...I don't know how difficult that is to capture but just a little bit more detail because currently in its current form, as I said, you just see the data as it is and they're all on a level playing field. But potentially, all that data is being collected in quite different ways and in different circumstances so just a little bit of context there would help I think.'* (Commissioner 1)

'*Some young people will feel comfortable, take the pen and do it on their own, and then we'll discuss it after they've done it, but others will want or need you to read it out to them. So it depends on the individual really.'* (Provider 14)

'*... considering you know that service user well … Say for instance I need to do a review today on a client and I know I've been working with them through their crisis and I know their situation, I know what's happening at the moment, I could potentially fill that in … I think it's just those more emotive, the more specific stuff to do with them that you wouldn't be able to…'* (Provider 17)

'*Maybe there could be an option where we've said we've either directly done it with them, or we've indirectly given the information from a conversation.... Sometimes you have to pick your moments, with anybody, when it's right to talk about something like that? With a form in front of you that tends to just close them down straightaway anyway because they are just like why are you writing about it.'* (Provider 16)

Another difference which was explored was whether a partially completed form was of any use, in particular whether a form which only recorded Section 1 (substance misuse) was better than no submission at all.

'*Is something better than nothing? I think it is, yes. I mean again, it comes down to how the form is put together. You could almost have these are the key points that we would want to complete in to get agreement among providers and commissioners that these are the real important things we're looking at, maybe some of the high level key outcomes.'* (Commissioner 1)

'*Obviously you find out the information from them but just not in that form way, so I could probably, especially the drug side, I could fill that out off the top of my head for my young people. But then it's defeating the object of actually asking them what they would write on. ... the emotional wellbeing side would be more difficult ... you would never guess for somebody what they would put for that.'* (Provider 16)

Some participants also felt that where a form should have been completed but it was not that this should be recorded. That was thought to be particularly important in the case of missed reviews or exits. Here it should be possible to note that a review or exit was expected but that it had not been completed, maybe because the child or the situation was too chaotic and it was more important to ensure the safety of the child. Where this happens the reason should be noted.

'*Although you're missing the data for that particular review for whatever reason, at least you know it's been missed, whereas if you're not even aware of it, if it's not being flagged up, then yes, it's just being missed completely, isn't it? ... I think that would be useful, again because like I say, it will just help to keep consistency really because in an ideal world, like you said, it would be completed every time but you've got to be realistic of the young people and the pressures that the key workers are under, that it's not going to be done every time.'* (Commissioner 1)

'Some of them their lives are so chaotic that every time you are going out there are such important things you've got to deal with that paperwork just is never brought out. Others then would become

chaotic while you were working with them, so I would sometimes be able to do an open one, but then actually as you go along and get to know the young person there is so much going on that it was never an appropriate time to get a form out to do with them. ... and sometimes you're just in the middle of a situation where everything is blowing up in a house, or young people are trying to avoid seeing anybody so it's literally just if you can give them a lift somewhere just so can see them. But at that point then you can't do anything, it's just checking they are alright really is the best you can do. ... the ones that ended up getting reviews and exit were the less chaotic ones .... which isn't capturing then probably the information that they [the WG] *most need to find out.'* (Provider 16)

The mechanisms of completing the Tool

There were very different views on how the Tool should be implemented and, at times, these are difficult to thread together. However, this section draws out the main points discussed by the participants.

'*The reports that I've had from speaking to the workers it's fairly simple, straightforward, self-explanatory to use, they've have no problems with using it. There are some things that they felt needed to be tweaked, but as far as the usage of it, it seems to be flowing and fairly quick to fill out.'* (Provider 5)

Children need to understand the purpose

Many providers reported reluctance on the part of the children and young people to complete the Tool. In many cases they failed to understand its purpose. Explaining the purpose might be simpler if it was possible to get the information out in a child-friendly form so that you could show them their journey.

'*Although we haven't done a specific evaluation of this tool with our service users at this point …. there's still a lack of understanding from children and young people who've used our service about the need for some of the paperwork.'* (Provider 3)

'*… it would be great to be able to have something that you can enter the data on, which ... put together like a timeline to visualise their use, to visualise distance travelled. ... You know like a dot matrix or something like that, the closest to the middle you are the better, the further away from the middle the more problematic, so what you're looking at is getting closer to the middle and maybe more a rounder shape rather than this spiky star shape which shows chaos and all the rest of it. So I think then it's to address then different learning styles, because I think a lot of our young people are more visual.'* (Provider 17)

Is the form completed alone or with the worker?

Almost all workers say that they help the child to complete the form. With older children there might be a few who completed them alone but generally they are supported.

> *'With regards to who completes the form, from my discussions with the workers they found just working collaboratively with them and speaking, an informal way of filling it out it out seemed to be a lot easier than leaving it to them to do, and they felt a lot more comfortable because can ask more probing questions that come from the work around...?'* (Provider 5)

> *'From our point of view there might be forms that we ask them to do by themselves, for example if they're completing feedback about the service or about the worker, but for this sort of tool we feel that it should be a tool to talk through to ensure that you are getting a full understanding with that individual. Actually it wouldn't be best practice in the sense of working with children and young people to just stick a piece of paper in front of them and say, there you go complete that.'* (Provider 3)

> '*I think a lot of this can be teased out can't it from conversation, as opposed to structured questions.*' (Provider 4)

Is the form completed in person or over the phone?

Almost all the forms are completed with the worker, as part of a session and in person. Generally most respondents felt that the form should normally be completed face-to-face and as part of a session. However there might be times when this was not the case and the form, or parts of it, might be completed over the telephone.

> *'… if you were with a young person who you couldn't fill this form out because they were in crisis the option of doing it telephone, you are always going to have a welfare check maybe later on that day, you can just do it over the phone then.'* (Provider 2)

> *'I think are fors and againsts with doing it on the phone and doing it face to face, because if you've got someone with anxiety problems they are more likely to reduce barriers by not having someone face to face with them, so I can understand from both points of view. But as far as this is concerned from speaking to the workers they normally do things face to face because it feels as if it's more natural to draw more out of them'* (Provider 5)

There was some suggestion that it might be appropriate to permit the form to be completed by other means. So the form might have 'face-to-face', 'telephone' and 'other' options. However, whilst many wanted further options or platforms they might use to complete the form many did not understand why this needed to be recorded. Others wanted that detail to be recorded but not in relation to how the form was completed but more in relation to how the intervention was delivered.

'*Welsh Government are quite keen now for us to look to Skype and using the internet and social media to try to interact with young people, so I didn't know if it was worth capturing that as a category in terms of Skype or online.'* (Provider 7)

'I guess what are we capturing it for? Does that matter to Welsh Government? Does it matter to us? Does it matter to young people or actually is that something separate about service delivery and how effective that is and how that should be done?' (Provider 3)

'As commissioner I would be more inclined … I would like the one-to-one, face-to-face sort of interaction because there's plenty more things that can be done at that sort of point, so I would like to see more face-to-face stuff. ... I find it useful. .... because I've just done a health needs assessment and that was part of it, looking at online therapies and the growing number of households using internet and whatever to access services, using online discretionary support and things like that, so I find it useful sitting outside, but providers might disagree, I don't know. ... if you do face-to-face and the phone them back up because of the time or whatever the reasons to get it, do you tick both of the boxes' (Commissioner 3)

'*Something else a commissioner would want to collect is how many service … how many sessions were delivered face-to-face or however.'* (Commissioner 5)

<u>*Do you go through the form or have a conversation?*</u>

Some workers ask the children the exact questions whereas others have a conversation with the child which encapsulates all aspects of the form and then they complete the form drawing on that discussion. Where the form is completed as part of their discussion it is considered part of their treatment.

'It's about actually it being part of their treatment and a piece of what you're doing, rather than it's sitting completely outside of that. ... I think the other bit for us sometimes is we work with young people who might have literacy issues but actually maybe have had a really negative experience of say maybe education as a whole, they don't like paper, so you have to engage with them and work with them with often no paper involved. So I think you've got to be quite creative sometimes as to how you capture that.' (Provider 1)

'So you might actually have a conversation and end up filling out something later on in the Tool before you look at what's at the beginning, because like you said you're not sitting asking young people a list of questions, you are having a conversation about things that you need to cover. Then you as the worker are taking the information that they give you and transferring that into the form.' (Provider 3)

'It's about making it a bit more natural I guess and a conversational process. ... it's about making the process more natural, rather than it always just be about going through question by question if you can. But it's tailored depending on the individual really, it would be done slightly in a different way depending the young person that you've got in front of you ..... depending on what's going on with that young person at that moment, for that appointment, different situations, and different circumstances.' (Provider 6)

'... every appointment, and probably for everyone around the table every young person you've done this with, will be slightly different because that young person will be slightly different.' (Provider 1)

How long to complete

Clearly where the form was completed as part of the treatment, as a conversation there was no indication of the time it takes to complete it. Even where the time taken could be measured there was no clear answer as each child differed and each completion with each child might also be different.

'*it depends on the young person and sometimes you're asking these questions and you know it's going to open up a whole host of discussion that you're going to have to deal with before you can...and sometimes you don't get to finish it then because you've got to focus on whatever the young person has brought up from answering one of the questions. So it could be 30 seconds and it could be that you don't even get it finished.'* (Provider 13)

Four weeks

Whilst all those involved in the research considered that the 12 week gaps used with adults for TOPs was inappropriate for use with children and young people there was less agreement around the ideal time intervals at which this tool should be completed. Twelve weeks was considered too long in the life of the child. Many of the providers and workers were very happy with completing the Tool every four weeks as had been done during the pilot whereas others believed a six or eight week interval might be more appropriate.

'*Six weeks is a long time for young people, monthly has been working quite well for us.'* (Provider 4)

'... I was quite surprised initially about how positive the feedback was about the four weeks because it's been a shift from the three months to the four weeks. But yeah across the board all the staff, and feedback from young people is that they definitely prefer that more regular completion.' (Provider 6)

'... monthly review is much better when you are capturing young people, because three months, you will be lucky if they might still be in treatment in three months. But actually some of mine have said that they've started to do this at every appointment, so it might be once a fortnight, and that's given a different picture, but actually the young person has got very used to it, they've actually quite liked doing it. Also they are using it to track their progress, so it's becoming part of their piece of work. So the feeling seems to be you could do it every appointment if you wanted to, there's scope that you could do it in that way, but the month rather than the three months was the big thing that came up.' (Provider 6)

'That's actually quite a good point, if you do it very frequent, and you can put it into a system where they can have some picture or orientation of how they're tracking, how they're feeling and things like that, that's a really good way of helping. Because it seems almost like a CBT approach really, like a mood diary or something like that, you can track at what points were they feeling good or bad, and correlate it against drug use. So I think that's a really good way of doing it.' (Provider 5)

'So I think that monthly requirement at the moment is great ... for us if there was an expectation to do it every session what that might mean is that actually you are unable to get the therapeutic interventions completed with that young person.' (Provider 4)

'… these type of tools can fit into the work you're doing, but you need that scope to say right this is your marker, you have to submit one at this point but you've got that flexibility to use it in between, that seems to work' (Provider 2)

'Four weeks it's meant to be done and four our young people it's too much. ... It's, from our point of view, too often.' (Provider 9)

'I'd say if you could time it when you refer your care plans, and for us it's every six weeks we review a young person's care plan, then that might fit a bit better.' (Provider 13)

'I was saying well what's a better timescale and they [the children] *said six to eight weeks'.* (Provider 12)

Whatever the official interval there was agreement that there needed to be flexibility because sometimes completing the form might interfere with the treatment of the child or with the therapeutic relationship and the needs of the child mist come before those of management or of the WG.

'I would hope that we can have an element of you are working with that person in the forefront, of actually if it means that you don't complete that review until the next appointment next week I would rather the team make that decision and say no it's okay, we'll put this to one side. We'll concentrate on the here and now, and if when we come to do the spreadsheet it's a week after then so be it, rather than us railroading a young person into doing something because it kind of meets what we need, and we are completely missing the point.' (Provider 6)

'.. allowing the team to have their own professional judgement with regards to filling the form in, because we want it to be more a process driven exercise as opposed to a task driven exercise. Because if it's process driven then it's working with that client, and maybe they're not having a good day for maybe whatever it is they're not having a good day ... But sometimes filling a form out may help in some way, depending on what the situation is, but it shouldn't be forced on anybody, and if it delays for a day or two that's nothing in the big picture.' (Provider 5)

Not able to complete the form

There were occasions when the form was only partially completed. Whilst everyone agreed that if the needs of the child dictated that completing the form was inappropriate they might submit a partially completed form they recognised that this might jeopardise the efficacy of the data.

> '*… if there are safeguarding issues, if there are crises, and actually you may get the section one things about their substance misuse at the moment. But then when you move onto other things, or you may start on a scaling thing around their health and wellbeing and that may draw out something that's a real priority or a crisis situation for that individual at the time. So you are then unable to complete the rest of the Tool. I would second that, it needs to be about the young person being at the centre, so if they are unable to complete everything at that time it needs to be the young person at the centre.'* (Provider 3)

> '*… if you .. were unable to complete the Tool to the full extent would it be useful to then submit that at the end of the month so that you've got the partial data? Or would it be useful to keep that tool until you've got the full picture of the entire tool to then submit the next month? So that's a question that it would be useful to have more guidance on..... I don't know what other people think but I know for example for us at the moment if we haven't completed the entire tool we would then keep it before we uploaded and gave our statistics to our APB, and we would complete that before passing it on.'* (Provider 3)

> '*I would imagine if you were looking at it from data reporting though that if you leave fields blank that's going to cause problems for them to pull off the other end anyway, so I would imagine... they wouldn't want partial completed .... so I would guess that you would hold it off, because your validation type errors would come then.'* (Provider 1)

> '*...if they choose to not answer then you can't make them, can you, it's their choice.'* (Provider 9)

> '*If they don't want to answer a question then we wouldn't push them to answer it. It's their form, it's their information, isn't it? ... Sometimes I've been guilty of abandoning it. I might get two questions in and then I'll think this isn't important right now, we need to deal with what's come out of the session and then I wouldn't necessarily go back to it then.'* (Provider 13)

Many asked for clearer guidance on this and other issues.

> *'… do agree that there should be clear guidance with regards to filling out the form, and to highlight issues like that, especially where it comes to... the grading elements'* (Provider 5)

The Tool

Not sufficiently child-friendly

Many felt the form was still too adult oriented and needed considerable work to make it more child friendly. The wording was seen to be too harsh and too complicated which then caused young people to be less inclined to complete the Tool. For some workers the negative effect was so great that they would not be using it if they were not required to.

> '*It's quite an adult tool, isn't it, the questions and things, they're not questions designed, I don't think, for young people.* (Provider 13)

> *'… if I'm being honest …. from our perspective and the feedback we get from young people they are not comfortable with the questions they are being asked. .... They don't particularly like doing it because of the wording, if I'm being honest and because of the effect some of it has on the young person. They're not that keen to do it but they know they have to.'* (Provider 9)

> '*… with regards to some of the wording of the questions on the second page, for the majority of service users when I've gone and used that, they really struggled with the wording of it.'* (Provider 14)

> '*I think that poses a problem when we're working with young people is every worker is probably going to explain that slightly differently. The tool should be written differently essentially because then you're going to get more of a true reflection. A form that's young person focused, it should be in young person's wording so they can understand it.'* (Provider 15)

There was also some concern with use of the word 'client' on the form. This was felt to be disrespectful and not at all child-friendly.

> *'I don't like client on there. Young person doesn't identify with that'* (Provider 3)

For use with which clients?

All workers recognised that the form was always to be completed with clients who were users. What was less clear was whether it should also be used when they were working on prevention cases, children and young people who are at risk of becoming users, or with those who had recently desisted but were still in danger of relapse or even with members of a user's family.

> '*… if they're still with you on a care plan then you'll still be doing this but they could be, like you said, not using substances so it needs to be recorded somewhere.'* (Provider 13)

> '*I suppose that's the approach we've been taking is that these young people are vulnerable to substance misuse and that's part of our role is to work with people who are vulnerable, not just people who are using substances.'* (Provider 12)

'Relapse, prevention and with regards to youth justice, was it prevention and statutory, I think, because you can get very different engagement with this from statutory and voluntary young people within youth justice.' (Provider 13)

'*The relapse prevention I think is good, identifying. So if you've got someone who actually their use hasn't changed from last time because they're still maintaining abstinence I think is really useful. I suppose it was a question for me in the sense of the hidden harm work, as in if you're not using substances and you're affected by parental substance misuse, did Welsh Government envisage this tool capturing that information or not because I personally hadn't, but there obviously isn't a clear understanding about that. ... what that would do would then stop the errors if that is what you're using it for, stop the errors of so many fields being blank because they would be irrelevant. ... But we need clarity around that... Because actually if this is a tool for tier one preventative services then strictly speaking I would be arguing that it needs to be used by anybody doing tier one work who could be schools, youth services, absolutely anybody. ... I must admit I hadn't thought of it being used for either concerned other or preventative. I had seen it as a tier two'* (Provider 3)

'*We've used it with SIBs and it's been quite good. Obviously the majority of it is non-applicable but the scaling is good and it gets a good understanding of which part of the lives are the areas that they're feeling worst about. So I think it would be great if you just had a box or something that said 'concerned other' tick, so you know you don't need to fill any of that out'* (Provider 4)

'*… where it was a bit more difficult was when it came to concerned others because we weren't sure whether we were supposed to be measuring the distance travelled for our concerned others. Concerned others aren't using substances, or more often than not they're not using substances, it depends on the person obviously'* (Provider 15)

Young Persons Outcome Monitoring Tool			
Client ID		**Interview Date**	**DD / MM / YYYY**
Sex	Male ☐	**Interview type**	Initial ☐
	Female ☐		Review ☐
Age			Exit ☐
Transfer to adult services		Yes ☐ No ☐	
Method utilised		Face to face ☐ Telephone ☐	

Use N/A only if the client does not disclose information or does not answer

This introductory section of the form threw up very few comments. There was general agreement that 'Sex' should be labelled 'Gender' and that the answers should be expanded to include 'Transgender'. Some also suggested that it should be possible for a child to refuse

to answer this question and that there should be a choice indicating this possibility, something like 'Prefer not to answer'.

> '… *with the sex column you haven't got transgendered, I just thought that could be quite telling in regards to a lot of these issues if they identify as transgendered perhaps.'* (Provider 7)

Similarly a few thought that the transfer to adult services could be broadened so that the initial question would be 'Transferred' with possible answers 'to adult services' and 'other, please specify'.

Some suggested that one might have slightly different forms for initial, review and exit returns or that there should be spaces on the forms to add in particular information or to indicate that some information was not necessary. For example, in Section 1 the age of first use is only sensible on the initial form or when new substances are introduced, maybe it could be headed 'Age first used – complete once only for each substance'.

The only other question in this section which threw up any issues was 'method utilised'. Almost all those interviewed collected the data face-to-face so the telephone was not used at all. However, some noted that colleagues might have used the telephone and that they could envisage scenarios where that might be acceptable. For example, the telephone might be used if the child had problems in the session and the Tool was not completed, the worker might want to ring the child later to ensure that they were safe and could then complete the form over the telephone. Furthermore, if telephone was an option a few asked whether they could be completed on-line, Skype or social media. See the earlier section for a full discussion.

> *'I've always done them face to face.* (Provider 13)
> *We wouldn't do it over the phone, no way.* (Provider 9)
> *We wouldn't think about doing it over the phone.* (Provider 13)
> *Don't think it's appropriate personally.* (Provider 9)
> *I don't think they'd stay on for long enough'.* (Provider 13)

Section 1. Substance Misuse

How many days during the last 7 days have you used? On an average using day how much do you use and drink? Has this gone up, down stayed the same? How old were you when you first used the substance?					
	How many days used in the past 7 days?	**How many days used in the past 28 days?**	**On average how much did you have?**	**Has this increased, decreased or stayed the same?**	**Age first used**
Cannabis			**Grams**		
Alcohol			**Units**		
Opiates (illicit)			**		
Cocaine			**		
Amphetamines			**		
NPS – Specify			**		
Other… please specify below _____			**		
Other… please specify below _____			**		

***** Not submitted nationally. For quantity, use whichever measurements you find most useful***

Ounces to grams convertor

Ounces	Grams
One ounce	28
Half an ounce (1/2)	14
Quarter of an ounce (1/4)	7
Eighth of an ounce (1/8)	3.5
Sixteenth of an ounce (1/16)	1.8

Alcohol units convertor

Drink	%ABV	Units
Pint of ordinary strength beer, lager or cider	3.5	2
Pint of strong beer, lager or cider	5	3
440ml can of ordinary strength beer, lager or cider	3.5	1.5
440ml can of strong beer, lager or cider	5	2
440ml can super strength beer, lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9
Glass of wine (175ml)	12	2
Glass of wine (250 ml)	12	3
Bottle of wine (750 ml)	12	10
Single measure of spirits (25mls)	40	1
Bottle of spirits (750mls)	40	30
275 ml bottle of alcopops	5	1.5

7 or 28 days

There was an almost overwhelming preference for only recording use over the last 7 days.

> *'I think that's also a good thing with young people, you ask them what they did two or three weeks ago and it's, like I don't know. Then you ask them in the last week and it's fine.'* (Provider 5)

> *'That was a big thing for us, massively preferred the seven days to 28 days, it was just so much easier to recall, and ... it's probably more accurate.'* (Provider 6)

> '*… getting young people to think about the last 28 days of their youth can be really quite challenging.'* (Provider 12)

> '*… a lot of them struggle with recalling what they've done for the last 28 days, the majority of them prefer just to recall what they've done for the last seven days, and some struggle with that.'* (Provider 14)

'I do the week one, I like that, and that led me on to doing a timetable with young people which I hadn't thought about doing before I had used that. So I found that really useful. .. when I started using that and actually asked them about the seven day they would say I don't know. I would say let's work it out then, and then it led me onto doing that type of timetable thinking, so that was useful.' (Provider 16)

On average how much did you have?

The units section was often cited as problematic. Taking cannabis as an example, there was discussion around the different terminology – joints, spliffs, bongs – and how these related. Some suggested that the young people often spoke in terms of weight, how many grams as that is how they bought it whereas others talked in terms of cost and may or may not be able to relate cost back to weight. With other substances there were also problems in measuring intake. A number of workers thought it had little to do with the amount used by the young person, or about their journey, rather they saw it as a way for the Welsh Government to measure consumption and some wondered whether this was a useful forum in which to collect that sort of data. However, others could see the treatment potential in knowing approximately how much their clients are using but would prefer it to be clarified in the guidance that this was only an approximation. For some however, this did not pose any issues, they were happy with entering amounts. There were cases where the child named an amount but it transpired that they shared it with others but unless the question was specific this might not come out so it might be best to ask 'on average how much did you yourself use'.

'I think there's a level of acceptance that it's going to be maybe a little inaccurate. ... crude, yes because when you were saying that I was thinking about a drug diary that we would often use with a young person. You can't always rely that the information is terribly accurate but what you can do is use that information to have a conversation with that young person about where their use is going. I don't get the feeling that this is for that ... this seems to me to be about consumption, about getting a reflection of consumption rather than about how much that young person is using.' (Provider 12)

'… that young person, the number of days they might have carried on using might be the same from the last review, but actually if they're cut the amount they're using by half or more, then actually that's a real positive outcome to see.' (Provider 4)

'… quite a lot of our young people will say I had a gram of cannabis but they actually shared it between four friends. Unless you ask that they say I had a gram' (Provider 16)

'It would really help us as well. (Provider 11)

'To have an idea on what they're using.' (Provider 10)
'It gives us something. I think so long as they are happy with a rough estimate, then that's fine.' (Provider 11)

'*… they'll all come out with different things, whether they're...just the different measures and the terms that they use. I don't know what you can do about that.'* (Provider 9)

'*I had a young person last week say it was a bottle of vodka and a crate of later and this, that and the other and I said to yourself, oh no between four of us. Right, okay, so then do I divide it equally by four?'* (Provider 10).

'To be honest, if you ask them though they'll tell you how many grams that they're using. I find it far easier with cannabis to work out than alcohol to be honest because they'll say I don't know, three grams a day easy.' (Provider 13)

Has this increased, decreased or stayed the same?

This question was generally seen as useful both to measuring the success of treatment and the journey. It gave the child a useful point at which to reflect on how their substance use was altering. The utility of this information was noted as there was no indication of the reason for the change, no explanation.

'*I think it's quite nice, this increased, decreased or stayed the same. I quite like that. ... Yes, I think that's useful for the young person as well'* (Provider 13)

'*It's probably better from a commissioner's point of view as well because that's all really what you're interested in is has their use increased or decreased really.'* (Commissioner 3)

'Well although a young person's use can increase and decrease for various reasons, it might not be that they've suddenly decided that they're reducing their cannabis intake. It might be that they've just got no money for the last two weeks or their supply has gone.' (Provider 12)

'… *has it decreased or stayed the same in relation to the last seven days or in relation to the last time you did the form. So we were doing it as in relation to the last time we did the form, but I don't know. I'd potentially argue that if they're being collated monthly it would be useful to look at that in relation to monthly regardless of when you're doing the tool because otherwise if you're doing it more often you wouldn't get the same measurement.. '* (Provider 3)

Age first used

The workers were perfectly happy with this question on the form and found that the children were generally happy to share the information with workers. However, this question was seen to be irrelevant on review or exit forms unless the child had started to use other substances since their last meeting and having to repeatedly answer it was not positive.

'*You only need to answer it in the initial really.'* (Provider 13)

'*What would be useful if that was on your initial one and then it doesn't need to be on the others unless of course a new substance comes up'* (Provider 3)

List of substances

Whilst all participants recognised a need to collect information concerning which substances were being used they questioned whether these need to be pre-listed down the side of the table. They suggested that the left column could be left blank and then workers and children could merely fill in information about substances that they are using. Those with this view considered that having to ask about each of these substances might even cause some problems.

'*But certainly feedback from our service as well is do we need this big box here or do we just need a box and then guidance about what people want filled in within it. So for example, do we just need a blank box and then the guidance behind it says 'we want you to stipulate cannabis, alcohol, opiates, NPS' including which one it is, that sort of thing. ... not having a set box there that means that if you don't need to put all of them in you've kind of taken up all that space. You would still need really clear guidance behind it so that it all fell into measurable categories. I think some of the other feedback that we had – and I don't know if this is echoed from any other services or not, is almost in having it there … I've got to be really careful about what I say, but does it become a bit of a tick list? It's like oh well I haven't used opiates, so that means that your use isn't as bad. I haven't used amphetamines, so that means that use is … I haven't injected, so actually that means I haven't got risky behaviour. So there's something about the options that are on there and I'm not implying that a young person is going to go, "Oh I shall go and use opiates and cocaine now because I haven't ticked that on my form." But there's something about that that actually by putting options there we are saying what we think is important about what they're using. That's some of the feedback our workers have given.'* (Provider 3)

'That's kind of the problem you see with TOPS at the moment. There's a few standard ones there and you've got to fill in a zero if it's not applicable rather than just not putting anything in. It would probably be better to just write it in.' (Provider 6)

Others assumed the list would remain but discussed what actual substances should be included. Some people reported that they were including substances such as tobacco and steroids. Some wanted to reflect the substance use as a whole and considered that understanding the links between these substances can sometimes be very important. Some wanted more lines to list 'other' substances.

'*I think given the correlation between tobacco use and other substance use, and substance use trajectories is really quite important.'* (Provider 10)

'*… we recording the steroid use on this front sheet because we have had some young people, especially in the summer months, injecting steroids.... Because I wonder if it needs a bit more space in this column to specify synthetic cannabinoids or stimulants and the additional space for things like valium, ketamine. I don't feel there's enough space there really. Not that I think it needs a huge table, just a few more...' (Provider 13)*

'I can only feedback what our workers have said and it's the opiates and the cocaine and the amphetamines. I would argue if you looked at stats, if you just want the top two, just put cannabis and alcohol and NPS and other' (Provider 3)

'*...the only one I was thinking about that was the cannabis one; do you split that one into cannabis and cannabinoid?... I think benzos is a good one because it's always worth keeping in, I think personally, because it disappears, it reappears, it stays around, and then it goes again.'* (Provider 17)

'*There's only three spaces effectively for me to measure that and only one of those is asking is this a new psychoactive substance, all of the substances she uses, albeit cannabis, are new psychoactive substances. So I suppose it doesn't allow you to cover everything because there's probably not enough spaces on the sheet itself.'* (Provider 15)

'We discussed putting an ever used box in to tick whether they've ever used it as opposed to currently using it. I just think if you're trying to get some of the young people to perhaps take ownership of it, they could almost sit there but, in my head, it would be good for them to have the whole list of all the drugs because some of them they don't think of' (Provider 10)

'Benzos like Valium, Benzodiazepines, they definitely should be, they are used quite often. I would say Valium, actually I didn't think of that, Valium would be a good one to be on there because that's probably the third most used substance' (Provider 16)

Some complained that only being able to list substances failed to capture some of the important elements of substance misuse. They noted that with poly-drug use it would always be helpful to know which was the primary drug and which was secondary.

'*…a lot of our young people ... will be dabbling in lots of other substances. ... on these forms it doesn't tell us which ones are primary and which ones are secondary … The Welsh Government, they wouldn't know which one is the primary substance, they wouldn't know which one is the secondary substance.'* (Provider 15)

<u>*Conversion tables for amounts of Substances*</u>

There was a general consensus that this information could be placed on a separate sheet so allowing more space for the inclusion of other questions.

'*The workers delivering them do it every day, so actually they know that information, so you think well does that need to be on there, whereas actually if you take that off, ...there would be room actually for more if you got rid of that.'* (Provider 1)

Section 2 Substance Misuse Specific Risk behaviours

Have you ever Injected? Yes ☐ No ☐

If yes have you injected in the last 28 days? Yes ☐ No ☐
Please note this does not include prescribed medication.

There was almost overwhelming support to either remove or alter this question. As other risky behaviours are not being measured the focus on injecting behaviour was very stark. Some workers even saw this question as damaging to the child's treatment. If it is felt necessary to collect information about injecting behaviour it was generally considered this could better be achieved by asking the means of delivery of each substance, this question could be placed in the table of substance use. By use of symbols the question could appear in Section one and the child could tick all methods that they have used (both ever and in the last 7 days). To be child friendly this could ask something like 'how do you use?'. Where risky means of administration were recorded some suggested that this might lead to other questions such as about the sharing of needles that the Welsh Government may be interested in. Overall, there was very strong support for this question to be placed in section one. However, it was to remain separate there was support for other risks to be taken into consideration, risks such as using alone and sexual exploitation associated with use.

> '*If they're disclosing use of amphetamines ... we'll have had the discussions so we know that that young person isn't injected amphetamine so therefore we don't need to ask the question.'* (Provider 13)

> '*I just find it quite interesting the substance misuse specific risk behaviours are all targeting injecting practices and that's probably the least... I've worked with two young people since I've worked here who have injected ... I think we're more at risk with young people sharing snorting equipment, using homemade bongs, sharing bongs and things like that.'* (Provider 15)

> '*I know feedback from other members of our team is that they find that quite harsh on young people and they don't necessarily like being asked it.'* (Provider 9)

> '*...because it's so rare for people to inject and they regard it with quite a lot of disdain'* (Provider 12)

> *I don't think there's a need for injecting there but that's because we don't come across under 16s generally who inject.'* (Provider 8)

> '*... how do you use, works a lot better than route of administration.'* (Provider 3)

> *'You could have methods of use, snort or inject.'* (Provider 13)

> *'Could you not put a symbol in for different methods of use'* (Provider 9)

'*… if we're looking for a risky behaviour it would be however the substance is ingested and the second would be other any shared equipment. Those are the only two things that I'd possibly want to see, because it's risk taking behaviour.'* (Commissioner 3)

'... our feedback around Section 2 substance misuse specific risk behaviours is could it be subsumed into that first section or if not could we be clearer about the wording that that isn't the only risky behaviour that you could be involved in. Because we do a lot of work with people around wider risky behaviours, around using by themselves, around potential for sexual exploitation, around those sorts of things and I think when we talk about risky behaviours as a whole, we're kind of looking much wider than that.' (Provider 4)

'*It's the sexual health stuff, sexual exploitation, that stuff I think is a big thing you'd be missing if we don't ask about that in that box.'* (Provider 4)

'*... if we had a question saying something like do you involve in risk taking behaviour, whatever the wording is, yes or no, and they have guidance at the back of it saying what risk taking behaviour is. When it's piloted if there's a lot of risk taking behaviour we can then say right okay, shall we break that down and see what other elements there are to it.'* (Provider 6)

'*And the young person wouldn't necessarily know that. Is it about their perception of risk and risky situations that they put themselves in? ... Because if you looked at it as a measurement if you're asking a personal question at the beginning, do you undertake risky behaviours? No. Actually you might do a piece of work with them and they recognise that and then they say yes and then you're measuring, oh bloody hell, the time they've been with the service their risky behaviours, actually it's gone from no to a yes, so yes, no, I don't know isn't clear enough. It's too complex for it just to be a yes/no question.'* (Provider 4)

'*I think we all agree that something needs to be put in with regards to risk taking behaviour. The actual debate of what needs to go in is something that we need to look at in more depth.'* (Provider 5)

'*...one of the outcomes that we ask young people to measure themselves when we do our kind of reviews and our assessments is whether they feel more able to manage any risky behaviours. So it's not asking them what their risky behaviours are, but it's asking them if they feel better able to manage any risky behaviours ...'* (Provider 3)

'*... get rid of Section 2 completely and in Section 3 you put down how well do you feel you're managing your risk taking or your risky behaviour – 0 to 10.'* (Suggested by Moderator and agreed by many in focus group)

A few participants suggested that the most interesting information concerning risk might arise by asking where the child got the money to purchase the drugs. Some thought we should record where the child sourced the drug.

'*… the bulk of work that I've had recently, I've had a lot of sexual exploitation cases. I think it's quite important to know that people may be buying them drugs or people are giving them drugs because that will highlight why are they giving you drugs, why are you getting it for free and things*

like that. ... we're so focused on substance misuse, we forget all the other things that come with doing silly things when under the influence of drugs.' (Provider 15)

'I find it more relevant working out where they are getting money from, and how they are going to actually get that money than injecting.' (Provider 16)

'*It would be street, illicit ... So you could have street; over the counter; friend; and I think really important is Internet.'* (Provider 17)

Section 3 Health and Wellbeing

How do you feel about your life? Think about how you feel at the moment.

Overall how satisfied are you with your life today? *(0-not at all satisfied, 10- completely satisfied)*	0	1	2	3	4	5	6	7	8	9	10
Overall to what extent do you feel that things you do in your life are worthwhile? *(0-not at all worthwhile, 10 - completely worthwhile)*	0	1	2	3	4	5	6	7	8	9	10
Overall how anxious do you feel today? *(0 – completely anxious, 10 – not at all anxious)*	0	1	2	3	4	5	6	7	8	9	10
Overall how happy did you feel yesterday? *(0 – not at all happy, 10 - completely happy)*	0	1	2	3	4	5	6	7	8	9	10
Overall how well do you get on with your family / friends? *(0 – not at all well, 10 -completely well)*	0	1	2	3	4	5	6	7	8	9	10

To begin with the whole section is headed health and wellbeing and yet there were few real health-related questions. It goes on to indicate that the form is trying to find out how the child feels 'at the moment' but then asks questions which are broader than this. If they are looking at their feelings at that moment they will be affected by being in the session and needing to reflect on their substance misuse. Many wanted to delete the subheading 'How do you feel about your life? Think about how you feel at the moment.'

'*… think about how you feel at the moment, well I'm stuck on a statutory appointment talking to you, not great.'* (Provider 10)

'*It doesn't need to be in there. It's just talking through*' (Provider 3)

'Around the feelings … around anxiety and how happy, well the thing is, everyone feels differently on a different day so that may depend on certain situational things that have happened so maybe it would be better to ask in general, on average lately, how happy have you felt or how anxious have you felt rather than on that specific day or the day before. I think you get a better idea then.' (Provider 3)

'*I would say it tends to baffle most of my young people when I'm doing the form with them. They tend to struggle filling in this bit more than all the other bits... So I think we're asking quite a lot from them when a lot of the questions overlap as well. So I think that could be reduced by just asking one question around health and wellbeing, one question around their family situation, one question around school. So I think that would make a massive difference.'* (Provider 15)

The 0-10 scale

The eleven-point scale was generally welcomed though some thought it might be represented by emojis, either instead of or as well as numbers.

'*I don't mean to be patronising but it could also use pictures of happy smiley faces and things like that. I don't know how anybody feels about that, but that could also be something that could be used. Because ... with young people if they don't understand, sometimes they can't articulate the way that they feel but they can identify from a picture how they feel.'* (Provider 4)

'*Our feedback was that that works really well for the younger children, but the older children it almost disengages them a bit from it because they feel like it's too young for them. So what we tend to do is we use different tools. So we might be putting pieces of paper on the floor, or something on the floor, and saying well stand where you think you are, or taking a selection of faces with you and you've got that in addition to the Tool. But I don't know whether that might be something that it would be useful to put across in potential guidance as ways that people might need to do it, or if that's actually how a good young person's worker would work anyway.'* (Provider 3)

The questions in Section 3

Overall this section was very negatively received. Workers considered that the questions were not child friendly, they needed to be re-worded. Whilst they were a slight improvement on the adult TOP that had previously been used, they should be made more appropriate for use with children. More fundamentally, many considered that these were not the correct questions to be asking. Some were even concerned that some of the questions could actually be quite damaging to young people. They seemed loaded and there were concerns that there could be some harm as a consequence of asking them.

'*One of the workers, ... fed back that she found the questions to be quite damaging rather than helpful. The young people were focusing on the negative rather than the positive.'* (Provider 8)
'*They're almost loaded aren't they towards the negative side, the negative response.'* (Provider 11)

'… *how do you feel about your life, that is such a broad question. ...they might be perfectly happy with their drug use, most of them are, but they don't like going to school. So that needs changing or being more specific or taken out.'* (Provider 8)

'*The emotional wellbeing I didn't find as useful because I found that the wording wasn't very appropriate for the young people, they would quite often ask me what that meant and what anxiety was. I can't remember it's the first, it's the worthwhile thing.'* (Provider 15)

'I think it's an awful question. ... If they want an overall, then it just needs much friendlier wording like how are things going or something like that. If they want specifics, you could break it down into school life, home life, different areas of their life if they wanted more specifics. So it depends what they're looking for.' (Provider 9, about the first question in this section)

'*I don't know what other people would think, but I personally find ... some questions the way they ask could be perceived as being quite damaging. Certainly they've got a very negative outlook and actually young people who use substances are so stereotyped anyway that to avoid coming from that negative outlook and have very neutral questions I think would be really useful. ... 'Because it's almost like your anxious one could be your mental health. Are you satisfied with your life one could … or the one underneath it could be your general wellbeing and then you're asking about their physical health as well.'* (Provider 3)

'*...for all these here there should be some good, clear guidance as well supporting these to explain exactly what is meant by each of them. I think that goes without saying with everything on the tool.'* (Provider 6)

'*We said it had to be taken out, rephrased, break it down into all elements, different areas, whether it was like home, school, education, different things'* (Provider 9)

'*They really struggle with the 'worthwhile' bit. Then it's difficult because it's being evaluated you don't want to put words into their mouths, they really don't understand that. I think every time I've used the tool that question has been a difficult one, they go what do you mean by that, what does that mean?'* (Provider 14)

Anxiety

The question about anxiety drew most attention from workers and providers as being inappropriate. They considered that it was an alien concept to children and one which they had great difficulty grasping. They were also unhappy with the scale in relation to this question, it was the other way around from all the others and so workers had problems getting it right, presumably children also had difficulties meaning that there might be a lot of errors in the data.

'*...for some young people, the younger ones tend to be, they don't necessarily know what anxiety is so unless they've experienced it and had almost labelled it I guess as being anxiety, they don't know what that is.'* (Provider 9)

'*...the anxious question, the massive amount of feedback was it felt the wrong way round.*' (Provider 6)

'*But my biggest bugbear with these four is the anxiety question because for me and for the first couple of months until I realised that it was the wrong way round, we were scoring it incorrectly because in my head, and in a lot of young people's brains, zero should be not anxious at all, 10 should be extremely anxious. It's the wrong way round.*' (Provider 13)

Family and friends

The workers were fairly unanimous in wanting to separate out family and friends. They felt that children rarely felt the same about both family and friends. Furthermore some wanted to break the family up into units (i.e. mother, father, siblings).

'*The last question needs changing completely. You need to separate out family and friends. A 14 year old's attitude to his family and his friends are completely different quite often.*' (Provider 12)

'*...family and friends, we've had a request from staff for them to be separate because that can be very different. …. when it asks you the question how anxious do you feel today and they are saying well not at all so I must be a zero, but actually you are saying no it's the other end completely. I think it took the staff a while to get their head round it, so actually young people really, and that consistently came back. …. I think it goes back to we either separate it out and ask specifically family, friends, school, the support you're getting or you put it altogether.*' (Provider 6)

'That's quite a good point as well because they can have an amazing relationship with the mother and an awful relationship with the father, and when you are asking them to generalise it can be quite...' (Provider 2)

'*Why are we asking that question? … It doesn't tell you anything long term, it just tells you what happens on that day.*' (Provider 8)

'*I suspect they work on the view that these things may influence substance misuse so your relationship with your family may have an impact on substance misuse. … Then vice versa I guess though as well, isn't it, so your substance misuse can have a massive impact on the other side, it depends what comes first...*' (Provider 13)

'*...friends is definitely something ... It gives us an idea of where they belong, what roles and functions they play in the community and whether they identify immediately with the community on their doorstep.*' (Provider 17)

What is the purpose of the Health and Wellbeing questions?

These questions are sitting on a form designed to track the child's journey through substance misuse treatment and yet some providers noted that the questions did not reflect that treatment, nor relate to it in any discernible way.

> '*It doesn't necessarily reflect the intervention at all. ... drug use might have stayed the same but her life... might have improved. ... Or equally, certain things may have happened in their life which has completely sent feelings and different aspects of their life off track. Then that may be what's impacted on their drug use, not the intervention having a negative effect. Whereas on paper, that might look that that's what it is when actually it's things beyond people's control.'* (Provider 9)

> '*....there's so many factors outside of the intervention control that always skew the results so it's flawed in its core really.'* (Provider 11)

Clearly whilst there is no direct link to these questions and the work most people recognised that the children's vulnerability was relevant.

> '*...that's the approach we've been taking is that these young people are vulnerable to substance misuse and that's part of our role is to work with people who are vulnerable, not just people who are using substances.'* (Provider 12)

Some recognised that if used as a clinical tool they could be quite positive, to permit the child to see changes in their lives over time, to understand their journey. A number used earlier answers as a benchmark against which to measure their feelings in the next review, so they might say note that last time the young person was a three and ask whether they now felt better or worse and by how much.

Concern over the interpretation and use of these questions.

What worried many workers and providers was what the information in this section might be used for. They wanted commissioners and the Welsh Government to understand that you cannot expect constant improvement and to recognise that a move down on some of these might actually be an improvement because the child has recognised a problem that they were previously denying. They wanted it understood that teaching children to understand issues or problems in their lives and then to deal with those was part of the work that they had to do with the children if they were to help them overcome the substance misuse. Therefore they reported that early on in their journey children might be expected to move down the scale before turning a corner and actually addressing issues. Furthermore, later in the treatment these scales would be expected to level off and maintaining stability would be a positive rather than a failure. They therefore wanted some assurance that the analysis of this material and the use to which it would be put by both commissioners and the Government would remain alert to these facts.

> '*You can't continuously improve otherwise I'd be doubting whether they weren't using drugs if they continuously improved because no-one is wonderful all the time. ... So I suppose it's acknowledging that people need to be stable, and they will fluctuate, and I think that needs to be acknowledged when we sent all this back, and they are collecting the data that that's recognised as not a negative thing, it's a normal thing to fluctuate. .... To jump on that again is that also you could have really good results at the start and then they could start dropping down to the working alliance between the worker and the client because they can trust them more, so they will*

give them a truer reflection of what's happening in their life. So they may feel that the first time they are everything is wonderful and brilliant, and then after time when the trust builds up the figures may go down.' (Provider 5)

'*...they could be under the influence when they come in and they think everything's wonderful, and then when they are no longer under the influence actually life is not as great anymore.'* (Provider 1)

'*...it can mean a lot of different things, and I think recognising all of the different things that it might mean, and like you said if you report a five and a five and a five, actually you might well have had a huge curve in between that, and actually for somebody maintaining that figure might actually be a hugely greater achievement than someone who has moved up one step'* (Provider 6)

'*...if the young person was having a particularly bad day on the day that you did the Tool then as far as how they get on with their families and friends, how they feel that things they do are worthwhile, they would automatically be lower based on their emotional or mental health at that time. … actually if you asked them 12 hours or a day later they might well be answering in a different way. So I think that's just something for us to be aware of in collecting and analysing that data.'* (Provider 3)

Section 4 Treatment Goals

Thinking about your care plan what treatment goals do you think you have achieved? *Please tick.*

None yet	Some	About half	A lot	All
☐	☐	☐	☐	☐

Thank you for completing the Young Person's Outcome Tool

There were a lot of different things discussed in relation to this section. Few people were happy with Section 4 but there were some different ideas about how it needed to be altered. Most people liked the fact that the answers were verbal rather than numerical but they did not like the answers 'some' or 'a lot' and they requested that these be altered.

'I think some of our young people weren't quite sure, they said well what's classed as some and what's classed as a lot. Because their estimate seems, you get into a flow with it I think, where it's structured, you put numbers, and then it seemed to come to the end and be really broad and general. So I know some of them said they'd had to talk through when they got to that bit and say well okay what would about half of your goals look like, or what would more than half. So I think it was the wording seemed very different to the other questions that they struggled. ... none, about half and all was probably alright, but it was the 'some' and the 'a lot' were the bits in between that they struggled a bit with.' (Provider 1)

'*I think with the wording it makes a bit more sense when it comes to goals and stuff. Rather than give a goal a number, I've done a bit of what I wanted to rather than, I've done four of what I wanted to do, that kind of thing.'* (Provider 7)

Regardless of the answers some people questioned its purpose and therefore questioned whether it should be asked and, if so, exactly what should be asked. There were those that saw this question as problematic and as potentially de-motivating whilst others thought it might be used positively in treatment (see below). Even those who recognised a question like this needed to appear on the Tool questioned exactly what it should ask.

'It can have a negative effect on it, because if it is at the start they're not going to have achieved their goals, so that looks bad against the service then doesn't it?' (Provider 8)

'And maybe for the young person if they are like, oh I haven't really done anything yet, but actually you've got yourself there, you've engaged in treatment.' (Provider 10)

'*Thinking about your care plan, what treatment goals do you think you have achieved?'* (Provider 9)

'*...here we are asking them what treatment goals we think they've achieved, would it be more useful to ask them how they feel about what they've achieved. So you are asking them about their feeling rather than asking them about their level of achievement.'* (Provider 3)

'...from a Welsh Government perspective I would've thought this would have needed to be more concrete if you are going to hold services in some ways accountable for the changes.' (Provider 6)

'...if they are wanting to look at the intervention, maybe they do need to ask a question on how helpful young people have found that.' (Provider 9)

'*...how many have you completed and how do you feel you've done so far? How proud or how satisfied are you?'* (Provider 5)

'*So progress. ... because achieve is a big word isn't it? It means you've gone and done it whereas you're progressing with it means that you're getting there.'* (Provider 4)

'*I like the bit at the bottom where they say how far they feel that they've come, and I feel that could capture more information, I think that would be useful. So if they think they've met halfway, maybe a question of what they feel they haven't achieved, to give you an idea.'* (Provider 16)

Whilst challenging these questions they also considered them to be important both for the child to see his/her journey but also for management to be able to evidence good work.

'*One thing that we liked about this as well, when you are talking about case manager as a whole, when you are closing down cases and stuff you've got to record them as treatment completed, drug free and all that kind of stuff evidences towards that as well. So if you can say this person has*

achieved a lot, or maybe not a lot but the majority of their goals then you could evidence that.' (Provider 5)

'To say as services if you've got people coming out saying they're about half is that going to be accepted as treatment complete, or are we saying that you only use treatment complete when all of the goals have been achieved.' (Provider 1)

There were suggestions that one might collect data about actual achievements and the child's perception of their achievements, or maybe the child's assessment and then that of the worker.

'*It would show you interesting data, wouldn't it, if you were looking at what had actually been achieved, and what young people felt they'd achieved. Then it would be interesting from a data point of view to link that to emotional and mental health. Because actually could someone have achieved absolutely loads but feel like they've achieved nothing, and what information does that give us about their involvement, engagement and support from the service. Or have you got someone that actually thinks they are doing great thanks very much, but their actual improvements as far as monitored outcomes are concerned are more minimal, but that's so important to them that they feel that would be really high in how they are doing.'* (Provider 3)

'*...if services were going to be [inaudible 27:31] or actually a percentage of your young people had said that they hadn't achieved any or they'd only achieved some rather than a lot, that could be a bit unfair because then you'd be in a position of actually as you'd have to get a young person to maybe relook or rethink. ... you might also then ... have a section that asked the worker; what do you believe the young person has achieved or the child has achieved.'* (Provider 7)

'*...how well are you doing? How well do you think you're doing? How well are you actually doing? It reminds me of if you're treating someone with hoarding and you have a hoarding scale and you show them all these pictures of hoarding and there's one that's completely immaculate, another one that's got everything to the ceiling and you say where are you on this scale and they'll always point at the lower ones which is really clear. But if ask them where do you think I think you are, instantly straightaway they turn around and say, "Oh you think I'm there with everything piled to the ceiling and things," so it's quite good to get an outside perspective of …. When you said what you think you are and what you actually are.'* (Provider 6)

'*...where do you think you are? Do you think other people would agree with that?'* (Provider 3)

Suggested changes and additions

The Tool needs to be made more child-friendly

Without being patronising many felt that the wording on the Tool needed to be simplified so it was easier for children to understand the questions unaided. For many providers this was not a priority because the worker either:

always goes through the form and helps the child to complete it; or

gleans the information from a general conversation and then completes the form drawing on that information, only asking specific rating questions and then only after they have been appropriately worded.

> '*I think it could do with being a little bit more young person friendly, how you guys do that is up to you, but it tends to be quite a clinical looking and worded piece of work.'* (Provider 14)

However, where the children completed them for themselves or with only minor support from their worker the wording is very important and, at present, it is inappropriate.

> '*... they're very adult worded questions, not young person friendly at all. So instead of, for example, how do you feel about your life, it could be just how are things going for you. Something as basic as that, it comes across so different to the person you're asking.'* (Provider 9)

> '*Needs to be termed differently because young people, what's wellbeing to a young person? They'd pick something there in their life that's negative whereas there might be hundreds of positives in their life.'* (Provider 1)

As well as altering the wording some wanted the form to look more appealing to children maybe through use of emojis or a more interesting design.
Another way to render the form more appealing to children would be to provide an on-line version. This would allow them to engage through a medium on which they are happy and also permit progress reports and other data on their case to be accessible and visible to them. This would have the added advantage that workers would not need to take the paper file with them to share such information with the child. Furthermore, children might be empowered to take greater control of their own treatment by being permitted to complete the form whenever they felt it would be useful.

> '*I know that young people in particular when dealing with any sort of issues that are potential barriers, one of them could be face-to-face meetings and I know there's been a lot of research done with youngsters with depression or accessing mental health services, but they overcome those barriers by using a text message or something like that. So maybe alternative methods of providing answers to this form could reduce barriers.'* (Provider 6)

> '*... if they had an online one, the young person you could see, and you wouldn't have to take the paper with you, their progress by pressing a button.'* (Provider 9)

> '*You would want to do a face to face one every so often, but regularly they could do the online thing themselves, and they might quite enjoy doing it and tracking their progress.'* (Provider 13)

> *'...* [there is] *a new system coming in, Asset Plus, which does that, it graphs events in a young person's life mapped with offences, so you can see the correlation between substance use, family breakdown, offending, and it's graphed for the practitioner, but also for young people. So there are systems out there that can do it, and we want it all singing and dancing then why not?'* (Provider 10)

'*... your point about social media was really good and if that is a way forward for engaging with harder to reach young people, if it is a comfort zone to be a computer that might capture that.'* (Provider 2)

'*So, for instance, having it as an app ... because on an app you can make it more aesthetically pleasing, more involved, whereas on a piece of paper it's very different.'* (Provider 17)

Measurement of risk

Almost unanimously participants felt that merely asking about injecting behaviour was problematic. They felt that it drew too much attention to that behaviour. This might be dealt with by moving that question up to the table and asking about method of delivery of the drug. However many also felt that two other areas of risky behaviour needed to be captured: sexual behaviour and offending behaviour.

Health and Wellbeing questions

Without being patronising many felt that the wording on the Tool needed to be improved, be made more child-friendly.

'... when we're talking about emotional health and wellbeing and breaking it down, I do think that's important actually. I think there's quite a lot of flaws with it. But I've just got an example here that we use with our team around the family, which is for young people, a distance tool. They break down health and wellbeing into eight different sections so it covers things like physical health and development, a young person's experience of good emotional health and mental wellbeing, their behaviour, communication with others including family and friends but separated family and friends, two separate things.' (Provider 11)

Most people also agreed that the Tool needed to capture information about more aspects of the child's health and wellbeing though they did not always agree which areas most needed to be included

'It would be interesting to find out how they feel about their substance use on it' (Provider 16)

'... from the very first meeting where there was so much we were saying that actually services could be capturing for young people, my feeling is actually the Tool that came out probably isn't capturing all of what we were initially hoping for. So I wonder if we took out too much of the other stuff. So I think education is a big one for us, we might make real positive strides around that and that's not captured anywhere. .... I guess my point is it wasn't as far removed from TOPS as I thought it might be, that's just my feeling.' (Provider 1)

'*I suppose healthy relationships would probably be more suitable to young people, talking about their partners and things like that.'* (Provider 15)

'*I mean we can't expect people to be abstinent from substances unless we're working on all the other stuff that's going on for them in their day to day life.... looking at their family, looking at their education, looking at offending behaviour as well, because that's quite a key thing. So I suppose if it encompasses everything.'* (Provider 15)

'*... so maybe having separate questions around mental health, emotional health, physical health, general wellbeing but the general wellbeing kind of would need to be at the end.'* (Provider 3)

'*I think there are other issues as well with regards to, for me a lot of the young people we work with are maybe struggling with education, maybe excluded from school. I don't know if that would fit into the tool just to map where a young person is with regards to their educational status, and maybe where they are with regards to their housing and accommodation status. Those are critical things with regards to the success of somebody's treatment. If they haven't got stability in those two areas then the risk factor are significantly higher and that might reflect an individual's treatment plan.... You can incorporate that into the tool because if it's at the review stage you can just check in to see if that status has changed at all, and it would just be a simple tick to say if they are still involved, and that will give weight then if their treatment wasn't as successful as maybe people think it should be. If there is a significant change in their accommodation or they've been excluded from school, then that would be evidenced there.'* (Provider 14)

The area that got almost unanimous support was the inclusion of questions relating to mental and physical health and emotional wellbeing. However, there were some people who did not consider this belonged on this tool as it was measured elsewhere.

'... having separate questions around mental health, emotional health, physical health, general wellbeing but the general wellbeing kind of would need to be at the end. So basically you'd be asking how are you feeling overall so what's everything look like rolled into one, generally how are you feeling, that sort of thing. ... Well there's mental health, physical health and general wellbeing. .. But yeah for us there's that catch-all question around any involvement with other services that actually tells us a lot. ... I think it depends what we want this tool for.' (Provider 3)

'*I've spoken at length with some of the providers ... about mental health and learner disabilities … is there a mental health issue? Yes/no. Has it been diagnosed? Yes/no, and exactly the same for learning disabilities because it's something that in our area anyway there's been a higher rate of young people with mental health problems that haven't necessarily been sort of diagnosed and it's a huge weight on social services and things like that. So I think it's important because I can see further down the line, if we can evidence that there's a lot of people that come through, then this possibly could affect funding streams eventually. That's the only reason I wanted to put those sort of things in. ... something like that should be flagged up with the Welsh Government through something like this because they'll see the figures straightaway.'* (Commissioner 3)

'*... that* [mental health] *would be on the assessment. Why would you need that to be measured on an outcome tool?'* (Provider 1)

The other areas that frequently arose as needing to be captured were accommodation status, Education, Training and Employment, levels of confidence and possibly levels of independence though this was recognised as being related to age.

'*... your inclusion and integration in education, work, training, wider community. One of the feedbacks that we have about that is that's way too much to go into one question because it could be good in one area and really poor in another area, but I don't know if there's something around that ...'* (Provider 3)

'*I think it's just something that gives some insight into some positive outcomes. You might have had a real positive impact on that particular area which isn't captured if it's not on there.'* (Provider 4)

'*... someone come into us for support and their substance misuse is off the scale, they're homeless, the last thing I would do personally would be to start focusing and looking at their substance misuse. I'd obviously start doing that, implementing some form of harm reduction, harm minimisation approach in the interim, however I'd be looking at, right let's sort out this housing issue first.'* (provider 17)

The guidance notes

There was almost overwhelming agreement that whilst these were useful they needed to be more detailed and cover more issues or possible situations that might arise. As noted above there were many issues that were being differently interpreted by each provider or even by workers within one provider. For example, who should complete the form and when the increase/decrease applied to – was it the last 7 days, the last time the form was completed or the last time the form was completed for submission.

'I think it needs to be a step by step, even almost like an idiot's guide to go through it clearly so there is no room for error or very minimal error.' (Provider 6)

'*Because I think the email highlighting all the discrepancies made it quite clear that people very differently have been using the tool. In a six month period there were lots of things came up that I thought god I hadn't even thought of that. And I suppose the bit around mentioning concerned others was a bit … now I would have never dreamt of doing a tool to capture substance misuse information for young people who don't use substances, but I guess I was kind of oh well I hadn't thought of that.'* (Provider 4)

'*... we weren't clear as to whether you just wanted us to put down the primary drug or should we list all of them.'* (Provider 14)

Summary

This section discussed findings from the focus groups and interviews (the qualitative research). The sample comprised commissioners and providers representing all 7 areas and all of the providers as well as commissioners from 5 of the participating areas. It also included an interview with 3 representatives of the Welsh Government. All of the

participants welcomed the Welsh Government's commitment to design a bespoke outcome monitoring tool for use with young people, there was a strong feeling that such a tool was necessary as many providers were designing their own but this was leading to a fractured understanding of the sector and its performance. They were also all supportive of the opportunity to participate in its design.

The Welsh Government were very clear about what they intended the tool to achieve. However, amongst commissioners and providers there were mixed views on exactly what the aim of the tool should be. There was general agreement that they wanted the Tool to cover similar uses to that made of the adult tool (e.g. measuring distance travelled).

The suggestion that the tool could and should do more (e.g. be linked to Key Performance Indicators (KPIs) and commissioners' outcome measures) is interesting but only really drew strong support if the idea is to design the KPIs around the data collected rather than collecting more data in order to meet KPIs and commissioner's outcome measures. So this was more a plea for joined up thinking by the WG and commissioners in relation to the design of outcome measures and KPIs.

As was found in relation to the analysis of the completed surveys there was discrepancy over whether the Tool was achieving its aims, even the very focused aims set by the WG, to measure the effectiveness of interventions for children and therefore to capture the treatment journey.

All of the providers had read the guidance notes on the use of the tool and had found these useful. Whilst each provider separately was reasonably happy with the guidance it was clear, especially at the focus groups, that there were aspects that were being very differently interpreted by providers and sometimes by workers within the same organisation. To ensure that it is meaningful to analyse data against each other there needs to be consistency. There is therefore a need for tighter guidance notes to ensure as much consistency as possible in the use of the tool. However, it was recognised that even with carefully constructed guidance notes there will always be some room for differences. Furthermore there always needed to be certain aspects around the way in which data should be collected that should remain at the discretion of the worker/provider. A number of these choices were clinically led e.g. whether to ask the questions very directly or to complete this as part of a wider intervention and there needed to be lea-way in order to allow professional discretion in particular cases. Complete consistency is neither possible nor desirable. Therefore the tool should record some of the common differences to ensure that when data are compared the comparison is valid e.g. a box indicating who completed the form and under which circumstances.

Most workers helped children to complete the form, this was partly because the language in the Tool is insufficiently child-friendly and partly because these children often lead chaotic lives and need support to collect their thoughts.

There was disagreement over how frequently the tool should be completed and submitted. Those working with children with acute substance misuse problems who often saw their clients frequently, were happy with having to complete a form every four weeks. Some

even said that they used the form more frequently, every two weeks. Whilst everyone recognised and accepted that the form needed to be completed more frequently than the 12 weeks required for the adult TOP, others considered that four weeks was too frequent and would have preferred every six or even eight weeks.

In discussions concerning the content of the form these were the most frequently accepted views: replacing the word 'sex' with 'gender' and adding 'transgender' as another option; only asking for information over seven days; only asking 'age first used' on initial completions and when new drugs have been tried; retention of the question on increase/decrease/staying the same; removal of the tables indicating the amounts of substances to make more space for other questions; move the questions on injecting to the table in Section 1 in a column headed ' what is the main way you use'; completely revise the questions in Section 3 (although retain the scales) and ensure that the wording is child friendly; in Section 4 retain a scale based on words but revise the wording to remove the words 'some' and 'a lot' and consider including other questions.

6. Discussion and conclusions

This report has presented findings from the evaluation of Phase 1 of the pilot of the Young Persons' Outcome Monitoring Tool. The evaluation used a mixed strategy approach in which qualitative and quantitative data were collected and analysed. The main aim was to establish whether the Tool was fit for purpose. In this chapter we summarise the results of the evaluation and highlight the key issues that emerged from the research. The chapter begins with a discussion about some of the broader issues relating to the Tool. It then considers the content of the Tool and makes tentative suggestions that might help to guide Phase 2 of the pilot.

Aims of the Tool

When considering whether the Tool is 'fit for purpose' an important starting point is to establish precisely what that purpose is. In other words, what does the Tool aim to achieve. There was agreement among all those who participated in the evaluation that monitoring the outcomes (or distance travelled) of young people receiving substance misuse treatment in Wales was a core aim. There were differences, however, among respondents in terms of how they thought the data should be used. These differences seemed to reflect the roles that the respondents played within the substance misuse field. WG were clear that for them, the data would not be used to examine individual providers (perhaps a job for commissioners) but rather it would be used to measure progress and effectiveness across the sector as a whole. Commissioners and providers, however, saw the Tool almost in clinical terms as part of the interventions undertaken with young people. There was a general consensus of opinion among these respondents that the Tool should have relevance for each child and be used to help a child see his/her own journey. Ensuring relevance for the child also increases the likelihood that it will be completed and therefore increases the validity of the data.

Inevitably, there were differences among respondents concerning how much information needed to be collected. While WG were keen to minimise the burden of collecting data, providers saw the benefits of using one tool to collect data on a range of issues beyond the needs of WG. For providers, measuring progress would be more effectively achieved by gathering data on a wide range of issues including the indicators set by commissioners and WG as well as issues such as physical health, mental health, accommodation, sources of drugs, and funding of drug use. The benefits, particularly in terms of the consistency that the use of a single tool could provide across services, were highlighted. However, it was also recognised that the Tool should not be used so rigidly as to interfere with the delivery of interventions. We will return to the issue of implementing (or using) the Tool shortly.

The target population

The next important question to consider is 'who is the Tool designed for'? In other words, what is the target population? On the face of it this may seem fairly obvious. In practice, however, this was far from the case. Throughout the evaluation, questions pertaining to the target group emerged. Of particular interest was the finding in the quantitative analysis of data submitted by providers that 18 people aged 18 and over were included in the sample. While it may be expected that some young people aged 18 might be included (to support their transition to adult services perhaps, or to bring their treatment to a conclusion) the inclusion of older people seems at odds with the Tool's focus on young people aged 17 and under. It was also of interest to note some confusion among providers regarding the appropriateness of the Tool for non-users. For example, should the Tool be used for young people receiving support to cope with family members with substance misuse problems or for preventions cases? Clear guidance on this would help to ensure consistency across providers. Such guidance would also be useful to ensure consistency in the types of drug recorded on the Tool. Some providers, for example, recorded tobacco use[2] while others did not.

Data issues

As part of the pilot, providers were required to submit electronic copies of their data to WG at regular intervals. The data were submitted in separate Excel Workbooks (one for each month) each comprising three sheets. This method of data collection presented several problems to the providers and also to the evaluators. The Workbook was set up in such a way that made it difficult for providers to include data on multiple drug types. This resulted in confusion among the providers in terms of what to include and difficulty for the evaluators in creating a coherent database suitable for analysis. A discussion on this issue might not seem wholly relevant given that this system will not be used when the Tool is formally launched in April 2017. However, there are lessons that could be learned from this exercise that could feed into both Phase 2 of the pilot and the final version. Perhaps most importantly is the need to test the system prior to its implementation. It is important that the system is user friendly and that it enables consistent data to be collected across areas and providers. The elimination of missing cases is crucial for some questions, particularly those in the first section of the Tool in which identifying information about the young person is collected. The date, for example, is of vital importance if change or progress is going to be effectively monitored.

There was general consensus among providers and commissioners that feedback (i.e. reports based on data collected using the Tool) would be useful not only for their own areas and services but also for the young people being supported. Some highlighted the benefits of feedback in terms of identifying examples of best practice that would serve to improve services generally across Wales. Others emphasised the importance of showing young people how far they have (or have not) travelled in their treatment journey, this

[2] The use of tobacco/nicotine is included in a separate field on the Young People's Specialist Substance Misuse Outcomes Record.

requires child-friendly and visually attractive outputs. With these benefits in mind, developing publishing strategies (internal and external) might be a useful way of ensuring that knowledge is routinely disseminated and of encouraging the engagement (and supporting the progress) of the young people that the Tool was designed to help.

Completing the Tool

Throughout the evaluation differences were reported in terms of how the Tool was completed in practice. Variation was noted in terms of who completed the Tool, when it was completed, how frequently it was completed, and also in terms of what information was recorded on it. These issues are important and need to be monitored and controlled for if valid comparisons are to be made. One solution might be to provide clear guidance that removed any scope for variation in implementation. Alternatively, additional fields could be added to the Tool to record variations that could then be controlled for in any analyses. For example, if there is no requirement for the Tool to be completed with the young person, then a question could be added asking how in practice the Tool was completed with various options provided. This would help to ensure that entries completed in the absence of the young person are clearly identifiable. Similarly, if there is no obligation to complete the Tool at a particular point in the session, then options could be given to record when it was completed (e.g. at the start, middle or end of a session or at another time altogether).

The problem of missing data (or unanswered questions) was highlighted in the quantitative data analysis and also in some of the interviews. Variations were noted in terms of how much data were included. One entry, for example, actually recorded that the review could not be completed. Others contained no information about drug use while others contained no answers to the questions in Section 3. These variations raise the interesting question of whether something is better than nothing. Is partial completion better than no completion? The danger of limiting responses to only wholly completed entries could mean that the most chaotic young people (or the young people with the most chaotic lives) could end up being excluded from the dataset because they are unable to provide all of the answers at that time. It could also mean that valuable data are lost for the sake of completeness. One approach might be to make certain fields mandatory (i.e. those in the introductory section of the Tool) and to include a question that gives the worker scope to state whether or not the Tool has been fully completed and if not, the main reason why not (e.g. failure to attend, environment too chaotic, YP too chaotic, other).

One final point relating to missing data concerns the potential benefits of developing a system whereby static (unchangeable) data are transferred automatically from one Tool to the next. The most obvious field here is the Client ID which should as a matter of routine link one entry to the next. Age of onset is another. If a young person provides information about the age at which they first used various drugs on their initial form, is there any need for them to provide this again? One exception to this, however, would be if the young person started using a new drug in the period since they last completed the Tool.

Content of the Tool

This section considers each question within the Tool and makes suggestions for alterations, additions and deletions. Each part of the Tool will be discussed in order. It is important to note that where exact words are suggested for questions these are not necessarily the most effective words which could be used, thought will still need to be given to ensure the questions are both clear and child-friendly. The need to ensure they are child-friendly is essential if this Tool is to be effective and we recommend that the next iteration be given to a number of people who work with children both in this field and related fields such as youth justice. We also recommend that a pre-pilot test is undertaken with a small group of children to identify any difficulties at an early point in the process.

Introduction

Certain fields in this section of the Tool should be mandatory and everyone agreed that they should not be altered. The Client ID, Interview Type and Age fall into this category. 'Interview Date' should also be mandatory though the title of this should be simplified to 'Date', meaning the date on which the Tool is completed. To be consistent with modern terminology the word 'Sex' should be replaced with 'Gender' and the answer 'Transgender' should be added. If the box also contained the option 'Prefer not to Answer' the question could also be made mandatory.

The question concerning whether or not the child has transferred to adult services is useful but rather restrictive; it fails to record other destinations or reasons for exit. To permit a fuller and more nuanced understanding of the child's journey it would be sensible to replace 'Transfer to Adult Services' with the following question and options:

Reason for exit: transfer to adult services, completion, moving to another service

Whilst almost all workers reported that both they and their colleagues almost always completed the Tool face-to-face there were some exceptions and these need to be recorded. However, the only other option, by phone, is rather restrictive and fails to future-proof the tool. There was strong support for an on-line version of the form. Providers are becoming less reliant on paper files and moving towards electronic filing systems. To cater for these changes we recommend that an on-line version of the form be designed, one which permits the information to be automatically uploaded thereby both saving workers' time and preventing errors in inputting data. This has the added advantage that it is more likely to appeal to children by allowing them to engage through a medium on which they are comfortable and so would increase the rate of completion. Designing an on-line version would also permit progress reports and other data on the child's case to be accessible and visible to both the workers and young people. This would have the added advantage that workers would not need to take the paper file with them to share such information with the child. Furthermore, children might be empowered to take greater control of their own treatment by being permitted to complete the form whenever they felt it would be useful for them. Therefore we suggest both the design and launch of an on-line version and the addition of 'On-line' to the answers to the 'Methods Utilised' question. Furthermore, the

Methods Utilised' question might be replaced with 'Was the form completed' and then the options.

Each provider had different practices about the frequency with which they completed the form. Some were finding it useful as a clinical tool, to show the child how they were progressing and they chose to complete the form at every meeting (maybe weekly or every fortnight), others only completed it when required to by the WG. Each of these practices is valid and it should be possible to enter all completions onto the system in order to download child-friendly outputs for use in treatment sessions. However, for data integrity it would be sensible to only count some of these for WG purposes. Therefore, there either needs to be a section on the form which records whether this version of the form is to be entered into the official analysis or the system needs to automatically pick out those entries which appear at the correct intervals.

There was some disagreement as to whether capturing data every four weeks was the correct interval or whether this should be increased to every six (or some even suggested every eight) weeks. Clearly the 12 weeks used for adults is too long an interval to be used for children. In the next iteration the interval might be lengthened to six weeks to discover whether this was preferred by workers and whether it elicited greater compliance. However, the guidance notes should state that more frequent use is permitted where that might aid treatment or is required for internal purposes.

From our research it is clear that there are many different ways in which the form is completed and it seems sensible to capture that information to inform the analysis. So, for example children, particularly those over 16, sometimes complete the Tool without help whereas some workers collect the data together over a session and then enter it onto the form, sometimes when the child is no longer there. This last method may be used when the child is particularly disturbed or their lives are very chaotic and they may not be in a fit state to complete a form. Rather than be prescriptive about how to collect the data it might merely be sensible to record how it was completed and, where the child is not present at the time of completion to recommend that some sections, such as the health and welfare section, be left blank. If this is to be permitted there needs to be a new question added to the form asking 'how was the form completed' or 'Who completed': YP alone, YP with help from worker, worker with help from YP, worker alone (after session). In the guidance it should be made clear that the final option is only to be used if absolutely necessary e.g. to capture data on the most chaotic cases, when completing a form is not an option and might be damaging to the child and to the success of any intervention.

There may be instances when the Tool can only be partially completed. For example, if the child is not present it would be difficult to score the Health and Wellbeing section. One way of dealing with this would be to exclude all of these forms but that risks losing important data and missing data on the most chaotic children, those in most need which will skew the data. Therefore for data analysis purposes such forms are important. For this reason if the tool has been completed in the absence of the child or it is only partially completed the reason why should be recorded e.g. failure to attend, environment too chaotic, YP too chaotic, YP became upset during the session, other.

There might be some advantage in recording the type of treatment: statutory, voluntary or both, though this is not a strong recommendation.

Section 1:

It is very clear that the Tool should only ask for data from the last 7 days so the column referring to 28 days should be removed.

The columns asking about how much was consumed and whether the amount had increased etc. worked well though the exact wording needed some alteration. The question about amounts needed to be more clearly wedded to actual consumption rather than what they 'had' as some children were answering maybe one ounce when it later transpired that this is what they 'had' but they had shared it with others. Therefore the question should refer to use (how much did you use over the 7 days or on an average day in the last week). The question concerning increase and decrease needed to record 'on average' to ensure it was not affected by special events such as birthdays etc.

The age first used is very important to record but, as noted above, should only be recorded on the initial form (unless a new drug is added to the repertoire). The information should automatically be added to review and exit forms through being linked to the child's ID number.

This table should then have a new column added to record the method used to take the drug. This question would replace that in Section 2 and would highlight other risky ways of taking the substance. The answer could be simply and effectively captured by use of a series of emojis depicting injecting, smoking, snorting, swallowing etc. and permitting the child to tick all those which apply. To capture information about the main method of imbibing the drug (if this is thought to be important, though the research suggests that this is probably not necessary) there could be a second column added asking this question.

The final new column which is suggested is to record how the drug was sourced. The suggestion here is to add the question 'what was the main source of the drug' with the possible choices of shop, online, friend, family, street dealer set out in the guidance. Several participants mentioned that collecting this information would be useful for WG to understand trends in the sources of drugs throughout Wales, this might also be useful to crime control agencies. It was also recognised that this information could be useful in the delivery of interventions with young people.

Finally in this section both the quantitative and qualitative analyses suggest that the wrong substances appear in the left hand column. Specific reference to opiates, amphetamines and cocaine should be removed as use of these substances was less commonly reported by this age group. The research also suggests that the broad NPS category should be replaced by specific reference to synthetic cannabinoids and mephedrone, which were the most commonly reported new psychoactive substances. Increasing the number of opportunities to record 'other' with a larger space to write in the name of the substance, is also recommended. This would provide the opportunity to report use of the less commonly

used substances such as opiates, amphetamines, cocaine and other NPS. It might be sensible for WG to review every five years or so

After the questions in Section 1 there are two tables which help to assess the amounts used, these should be removed to the guidance. There was little support for the inclusion of these tables and general opinion was that the space could be better used.

Section 2:

All the research suggests that the questions currently in this section on injecting should be removed. Some children were upset at being asked this question so directly and the research has suggested that it should be captured in Section 1 (see above) so permitting it to appear with other means of use and so softening the question whilst still capturing information about injecting.

In place of the present Section 2 it is suggested to include a new Section 2 recording information about other needs and risky behaviour. We would suggest the title 'Background to Substance Misuse'.

This section should include the following:

A question about their accommodation status offering a choice of answers such as 'secure' 'temporary' and 'no accommodation'.

A question about their Education, Training and Employment status offering a choice of answers such as 'secure and attend regularly' 'secure but fail to engage' 'no ETE'

A question about how they fund their drug use offering a choice of answers such as including: borrowed the money, crime, sexual exploitation, part-time job, full-time job and other.

Section 3:

This section produced most negative comments from workers, commissioners and the children themselves. The whole section needs to be re-thought and tied more clearly to health and wellbeing. Furthermore the questions need to be a lot more child-friendly. It became very clear that this section needed to be totally re-designed by deleting all of the present questions and replacing them with very different ones. The research found that Section 3 should include separate questions on each of the following:

physical health;
mental health;
emotional health;
relationships with family;
relationships with friends;
confidence; and
independence.

The 0-10 point scales should be retained by emojis should be added to the beginning and end of the scale to make this simpler for younger children and those with learning difficulties. It was felt important not to focus on the emojis or to replace the numeric scale as older children would find this insulting, just a sad face at one end and a smiley face at the other would be helpful. In order to allow a more positive presentation it might be sensible to consider reversing the scale (10 on the left and 0 on the right).

Section 4:

Section 4 was welcomed and recognised to be very important when measuring outcomes. However, in its present form the research suggests that it may not be properly capturing outcomes. The first alteration that the research suggests is that the question be re-worded to ask something like 'About how many of your treatment goals do you think you have achieved?'. The verbal scale generally worked well though many children seem to struggle with the terms 'some' and 'a lot' as they found them too imprecise. The problem was that it was difficult to find simple replacements. The suggestion is that for the second draft they might be replaced with something like 'some, but not yet half' and 'more than half but not all'. However, it may be that after evaluation of the second draft it is necessary to return to the simpler form used in this iteration. There is some suggestion that we might also add another answer 'too early/initial' although many workers included turning up to interventions as a goal and, in that case, they would have achieved something even at their initial meeting.

The research suggested that many children have unrealistic expectations and that it would therefore be useful to add two questions to this section. One question should permit the child to record how they feel about their achievements. The second should be the only question the worker should answer on every form. It should ask how many goals the worker thinks the child has completed. This is a very important question for two reasons: firstly, it gives the child a concrete assessment from a different perspective and might help them to approach their interventions more realistically and secondly, if the WG are using this to assess outcomes, it would be sensible to have both the child's and worker's perspective on progress, this would be fairer to overall figures and to organisations.

Finally, if the scales in Section 3 are reversed to put the positive answers first then the same should happen with these. Alternatively if the scales in Section 3 remain unaltered then these should not be changed.

Developing a revised Tool

The report and particularly this section may give the impression that people are very unhappy with the work done to date. That is not true. Participants welcomed a tool for use with children and appreciated the chance to input into its design. There is real enthusiasm to create something very new and something that can deliver a flagship improvement to anything previously used by government. As with any innovation there is an understandable nervousness to change too much but it is only by exploring all issues that a really useful Tool can be created, one that is useful to the children, providers, commissioners and the WG, and one that is useful not just for now but also into the future. It is with that in mind that all the changes have been suggested, they arise out of the enthusiasm in the sector to create the best Tool possible, not just make do with what is already used.

The researchers recognise that this report suggests significant changes to the Tool but these have been led by suggestions from workers and the children. The changes suggested in the report will allow us to capture the experience of children's substance misuse more holistically and interestingly they are also changes which fit well with the recent Social Services and Well-being (Wales) Act 2014 and with the WG's extended entitlement programme (Welsh Government 2000, 2002a&b). The report sets out extensive changes which might be difficult to visualise and would involve a lot of work to design. If that is a stumbling block to using these suggestions we would be happy to offer to design a new Tool which would incorporate as many of these suggestions as possible.

Concluding comments

This evaluation has considered whether the YPOMT is fit for purpose. The evidence presented in this report suggests that the Tool is not currently achieving its full potential. However, with some careful adjustments and the creation of clearer guidance there is scope to develop the Tool into something that meets the needs of WG, commissioners and providers. There is also scope to develop the Tool into something that meets the needs of the young people too. It is important to recognise that there is an opportunity here to develop a flagship Tool that better measures outcomes and supports children than either the English version which this draft so closely resembles or other available tools.

Above all, it is important to remember that these 'clients' are, as one respondent highlighted, "just children" who need to be safeguarded and treated appropriately. We therefore strongly recommend that any new version uses child-friendly language and is distributed to key stakeholders, including a group of children, for comments and testing prior to any future large-scale piloting.

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