Buckinghamshire Blue Light Project Evaluation Final Report

June 2025

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TONIC

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Executive Summary

What service users say about the Blue Light Project in Buckinghamshire

"The Blue Light project has probably partly saved my life to be honest."

"Blue Light Project is excellent. Much better than the normal service."

"Without this service, I am not sure I would be where I am today. I am currently 5 months sober and actually able to see a future for the first time in years."

"If it wasn't for [my Blue Light Project worker], I truly know that I would not be where I am."

"I am very impressed with the Blue Light Project. Without the service I would not be where I am today. When I was in the crisis, I was lucky that the project found me. I was so lost, and the support offered to me was critical to my recovery."

"Blue Light Project saved me. The support provided and the confidence instilled in me is invaluable. I am now 10 months abstinent from alcohol! I had been in structured treatment multiple times in the past which I was unable to stick to due to the severity of my addiction. I am forever grateful this support was offered to me."

Context

Buckinghamshire Council and its partners aim to work together to utilise alternative approaches and care pathways to support people with an enduring pattern of problem substance use who have a significant impact on public services. The approach seeks to challenge the pessimistic belief nothing can be done for people who appear unable to change. The Blue Light Project approach asserts there are positive strategies that can be used with this client group.

The Blue Light Project consisted of two main elements:

i. An Assertive Outreach Team based within the local drug and alcohol treatment service (One Recovery Bucks) – consisting of 2FTE dedicated Outreach Practitioners with regular peer, clinical and management supervision. The team takes the service to people who need it rather than waiting for them to go into the treatment service. Many interactions will take place outside of traditional treatment settings. Smaller case loads enable the provision of intense support to stabilise chaotic and complex patients, preparing them for treatment. This in turn makes the programme different and resource intensive.

ii. A Multi Agency Group (MAG) – professionals from different agencies collaborate to identify eligible individuals and provide co-ordinated support. It ensures that no single service or professional is working in isolation particularly when it comes to addressing complex needs.

The Blue Light Project aimed to:

- Identify people with problem alcohol/substance use who are having the most significant impact on public services
- Improve management of high impact people with problem alcohol/substance use to improve their outcomes, including:
    - Reducing the impact and risks they pose to the wider community
    - Reducing associated demand placed on local public services
    - Engaging people into specialist alcohol and/or drug services or other relevant services

The Task

Buckinghamshire Council commissioned TONIC to undertake a two-year evaluation of the Blue Light Project in Buckinghamshire. The evaluation aims to measure impact and effectiveness, using both qualitative and quantitative outcomes and identify success factors and challenges to inform improvements and the future of the Blue Light project.

Methodology

The Buckinghamshire Blue Light Project provides an assertive outreach approach, that includes multi-agency co-ordination to engage and support people with high-risk problematic drinking and/or substance use and complex needs. This independent evaluation was performed between October 2021 and December 2024, concerning clients referred onto the project between October 2021 and May 2024, using a mixed-methods approach, combining quantitative and qualitative data. Quantitative analysis compared pre- and post-intervention service use for clients, using a pre/post design with Wilcoxon signed-rank tests to assess significance. Cost comparisons were also made using unit costs. Qualitative insights were gathered through observations, stakeholder interviews, and six in-depth case studies, featuring interviews with clients, Blue Light Practitioners and external professionals. Triangulated data informed key themes and assessed the impact of the project.

It is worth noting due to data limitations, we would suggest caution in interpreting the impact findings in this report.

Findings

Client Cohort: 44 people were accepted onto the project between October 2021 and May 2024. The majority (91%) were referred solely for problem alcohol use. Referrals primarily came from One Recovery Bucks (34%) and Adult Social Care (34%), with others referred by agencies including the police and housing services. In addition, of the 44 people referred, 77% (34) had current or previous interaction with mental health services. At the end of the evaluation of the 44 individuals, 56% (25/44) were closed to the Blue Light Project, and 43% (19/44) were still active on the project.

At point of closure from the project (25 individuals):

- 48% (12/25) had a positive outcome including successfully completing treatment on the Blue Light project or transferred to the standard treatment pathway and are engaging in recovery activities including volunteering.
- 12% (3/25) had a neutral outcome, such as leaving, relocated or rehoused in another local authority area.
- 15% (4/25) did not engage with the project having declined the support offer.
- 8% (2/25) were retained in custody.
- 15% (4/25) had died.

Longer term outcomes in relation to the 43% (19/44) still active on the project at the point of evaluation in May 2024 indicate that subsequently by April 2025:

- 16% (3/19) had successfully completed treatment, engaging in recovery activities.
- 84% (16/19) are still engaging with the project and are showing more stability, reduced high impact use of public services.

Service Delivery and Engagement: Where people who need support and do not come into services, services may need to go out and find them through Assertive Outreach. This means making time to work with people in their own settings, building engagement through persistent and consistent interactions. Assertive Outreach is a method for moving positively, patiently and persistently with someone across the gap between identification and treatment.[1]

Blue Light Practitioners delivered 2,923 support sessions, with a 65% attendance rate. Intervention types included, psychosocial support, harm reduction, health and wellbeing clinics, welfare checks, and multi-agency professional meetings. The average engagement duration across all 44 clients was 14.7 months, highlighting the intensive, long-term nature of the work.

Qualitative Findings: Six case studies illustrate how the Blue Light Project transformed individual lives through persistent, person-centred support. Outcomes discussed in these case studies included:

- **Housing Stability**: Five of the six clients moved from homelessness or unsafe housing to secure accommodation.
- **Reduced Alcohol Use**: All six clients significantly reduced or ceased alcohol consumption.
- **Improved Health and Wellbeing**: Clients reported better physical health, fewer hospital visits, and improved mental health, including reduced self-harm.
- **Connection with Family and Community**: Several clients re-established family relationships and became involved in volunteering or peer support roles.
- **Reduced Pressure on Public Services**: Professionals highlighted decreased demands on emergency health and criminal justice services.

Reductions in Service Demand: Across the cohort when examining the pre and post intervention periods, statistically significant reductions were recorded in police crime reports (down from 22.1 to 13.6 reports per year), police welfare referrals/calls (down from 12.7 to 8.2), and drug and alcohol service presentations (down from 1.5 to 1.1). Other reductions were observed in arrests and antisocial behaviour reports, though these did not reach statistical significance.

Cost Effectiveness: Average service use costs across the health and justice system fell from £57,200 per year in the pre-intervention period to £45,100 per individual per year post-intervention. While the difference was not statistically significant, the reduction suggests potential savings of approximately £399,000 annually across the cohort. The project demonstrated an indicative return on investment of between £4 and £5.70 for every £1 spent.

Conclusions and key learning

- While data limitations require caution in interpreting some findings, the overall evidence points to improved individual outcomes and reduced demand on public services.
- Buckinghamshire Blue Light Project appears to be effective at engaging people who typically fall through the cracks of conventional services.

[1] This is adapted from the "Alcohol assertive outreach: a handbook" published by Alcohol Change UK (updated February 2023) https://alcoholchange.org.uk/publication/alcohol-assertive-outreach-a-handbook

- The model's strength lies in its flexibility, persistence, and the holistic support offered.
- Client benefit is significant. Demonstrated through evidence of engagement with the drug and alcohol service.
- The Blue Light project has continued to build on the findings of the year 1 evaluation report. This noted positive partner feedback on improved practice, joint working and a more bespoke service being available leading to increased engagement.

Key learning from the Blue Light Project

- Recognise the extent to which vulnerabilities and individual circumstances impact on a client's ability to engage.
- Consider an individuals' mental capacity to engage, and also their ability to think, act and execute tasks.
- Where possible identify a lead professional/care coordinator to build up a trusting relationship.
- Build up strong relationships with other professionals, ensure information is shared appropriately. Reduce duplication of service inputs, coordinate support and work together on shared outcomes.
- Just because a person has not engaged in the past, does not mean this will always be the case. Be tenacious with clients.

Recommendations

- Given the evidence of potential system cost savings and improved outcomes for this cohort of high risk complex drinkers, identify recurrent funding to embed the Blue Light Pathway within the adult Drug and Alcohol Service.
- Maintain the current delivery model for Blue Light with the following key components:
  - Multi agency joint working for clients.
  - Smaller maximum case load allocation.
  - Regular supervision and training.
- Establish an ongoing Multi-Disciplinary Team (MDT) operational process to improve joint working and increase knowledge of effective MDT working.
- Continue to monitor the quantitative and qualitive impact of the Blue Light project via quarterly contract meetings.
- Disseminate the findings of the evaluation report to key stakeholders across the system.
- Longer term, consider future opportunities for joint funding arrangements with partners given the system-wide benefits of the service.

Acknowledgements

TONIC would like to thank the following people for their tireless help and support throughout the development and delivery of this evaluation: Cavelle Lynch, Liz Biggs, Lizzi Fairless, Josiane Dyson, Tracy Braddock and Rebecca Carlile.

We would like to thank Jodie Hopcroft and Dawn Barlow, the Blue Light Practitioners who allowed us to shadow them while delivering the service and to develop the case studies. We would like to thank the service users who engaged with the evaluation and allowed us to speak with them and shadow their appointments.

Finally, we would like to thank all those who attended the MAG meetings and supplied us with the data required to undertake this evaluation and to Mike Ward from Alcohol Change UK who supported the development of the Project.

1. Introduction

1.1 Alcohol Related Harm in the United Kingdom and Buckinghamshire

The cost of alcohol-related ill-health is a considerable financial pressure on the NHS. The Organisation for Economic Cooperation and Development (OECD) has estimated alcohol consumption is responsible for around 3% of healthcare costs in the UK, amounting to around £8.3 billion (OECD 2021). The Office for Health Improvements and Disparities (OHID) estimates the annual cost of alcohol-related harm to society in England to be around £21.5 billion. OHID also states alcohol treatment provides a social return of £3 for every £1 invested[2].

The most recent publication of the Health Survey for England found in 2022[3], 56% of adults reported drinking alcohol in the past week. This was a slight increase on the 2021 level of 55%, but lower than that observed ten years earlier (61% in 2012). Alcohol misuse remains a significant issue, and alcohol-related harm is a leading cause of preventable death. The government has implemented several measures aimed at reducing alcohol-related harm, such as increasing the price of alcohol through taxation and implementing restrictions on advertising and marketing. In Buckinghamshire, it is estimated 71% of dependent drinkers are not in treatment (NDTMS)[4]. Alcohol misuse can have a wide range of negative health, social, and economic effects, including:

Health problems	Excessive alcohol consumption can lead to a range of health problems, including liver disease, pancreatitis, cancer, heart disease, and stroke. It can also weaken the immune system, making it more difficult for the body to fight infections.
Accidents and injuries	Alcohol is a significant contributor to accidents and injuries, including road traffic accidents, falls, and assaults.
Mental health problems	Alcohol misuse is also linked to a range of mental health problems, including depression, anxiety, and sleep disorders.
Crime and antisocial behaviour	Alcohol is a factor in many types of crime, including violent crime, domestic abuse, and public disorder. It can also lead to antisocial behaviour, such as noise nuisance and littering.
Social problems	Alcohol misuse can lead to social problems, such as relationship problems, unemployment, and homelessness. It can also contribute to poverty and financial difficulties. These issues can be intergenerational.
Economic costs	Alcohol misuse has significant economic costs, including the cost of healthcare, lost productivity, and increased crime.

[2] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest
[3] Health Survey for England, 2022 Part 1 - NHS England Digital
[4] NDTMS - Home

Overall, alcohol consumption showed a decline prior to the Covid-19 pandemic, but it remained a significant issue with alcohol being the leading risk factor for disability and for death in working age adults (15–49-year-olds) in Buckinghamshire (Global Burden of Disease study, 2019):

- A greater proportion of Buckinghamshire adults than nationally were estimated to drink above low risk levels (25.1% versus 22.8%).
- A greater proportion of Buckinghamshire adults reported binge drinking, that is consuming 8+ units by men or 6+ units by women on a single occasion, than nationally (16.4% versus 15.4%).[5]
- A lower proportion of Buckinghamshire adults than nationally were abstinent (14.4% versus 16.2%).

A Buckinghamshire Council audit of drug and alcohol deaths identified 180 alcohol specific deaths in the county between 2020 and 2022. Its key finding was a 45% increase in the age-standardised alcohol specific death rate for 2020 – 2022, compared to ONS data from 2017-19. This was driven by a large rise in alcohol deaths in Buckinghamshire in 2021.

This is consistent with the sharp rise in alcohol deaths seen nationally during the pandemic. The leading underlying causes of death were alcohol liver disease (67%), alcohol toxicity (8%) and Sudden Unexpected Death in Alcohol Misuse (SUDAM) (7%).

Those who died of alcohol specific causes had a median age of 50-64, were more likely to be male and living in the most deprived areas of Buckinghamshire. Amongst those referred to the coroner, only half had ever received support from local drug and alcohol services.

1.2 Cost of Alcohol Related Harm for the Blue Light cohort in Buckinghamshire

National Cost – Alcohol Change UK [6] estimates that in an area with a population of 350,000 there are around 250 Blue Light-eligible individuals who cost at last £12-£13 million each year across a range of services.
Individual Cost – The national Make Every Adult Matter (MEAM) Coalition publication estimated a cost of between £36,000 and £48,000 per year per person meeting the Blue Light criteria across health, social care, criminal justice and housing services.
Local Cost – Modelling the above for Buckinghamshire based on a population of 535,198 translates to a potential 492 individuals who would meet the Blue Light criteria locally, costing around £21million across health, social care, criminal justice and housing.

Between October 2021 and May 2024, the Blue Light Project in Buckinghamshire identified and supported 44 individuals who met the Blue Light criteria.

[5] Local Alcohol Profiles for England - OHID (phe.org.uk)
[6] The-Blue-Light-Manual.pdf

1.3 The Blue Light Project

The Blue Light Project is an initiative developed nationally by Alcohol Change UK to develop alternative approaches and care pathways for people who have an enduring pattern of problematic alcohol use and who are not engaging with or benefiting from treatment.

This approach challenges the belief only people who show clear motivation to change can be helped and sets out positive strategies that can be used with this client group.

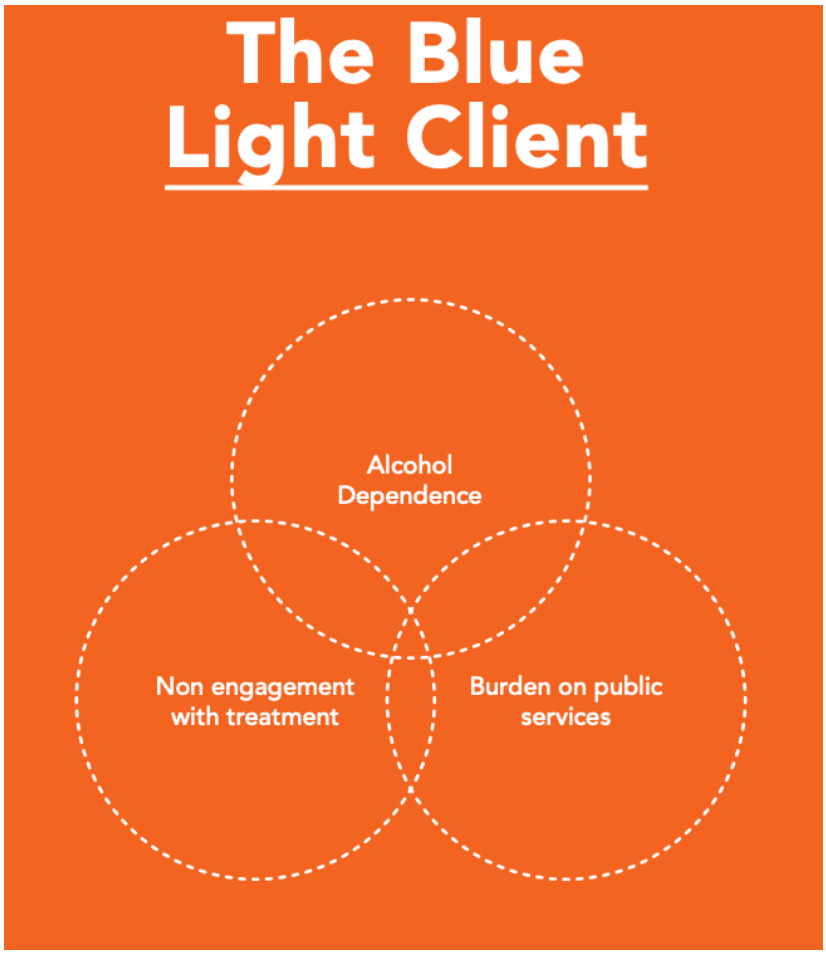

Figure 1: Diagram taken from the Blue Light Project manual (Alcohol Change UK, 2014)

At the heart of the Blue Light Project is a manual, supported by training and help in establishing multi-agency partnerships. It sets out the key principles and contains a range of advice and tools for working with clients who are not in contact with services. The training provided by Alcohol Change UK supports professionals in applying these principles and tools, and helps local areas set up the multi-partner forums and protocols needed to embed the programme. The manual contains:

- Tools for understanding why individuals may not engage
- Risk assessment tools which are appropriate for drinkers
- Harm reduction techniques workers can use
- Advice on crucial nutritional approaches which can reduce alcohol-related harm
- Questions to help non-clinicians identify where individuals may be at risk of serious health problems
- Management frameworks
- Guidance on legal frameworks

The Blue Light approach, while it may not always be possible to result in complete change, is an intervention that can help to reduce harm and manage the risk they pose to themselves and others. The Blue Light Project began as a co-production involving 23 local authorities. Local staff and service users in each area contributed expertise to the development. The Blue Light Project approach has now been adopted by many local authorities across England and Wales.

The key elements of local transformation in adopting the Blue Light Project approach are:

- Building strategic ownership of the need to tackle the client group
- Training of specialist and non-alcohol specialist staff in the Blue Light approach
- Developing a multi-agency operational group to ensure a joint identification and ownership of the highest impact clients
- Developing assertive outreach approaches by designing and evaluating services
- Improving the response of local alcohol services through staff training and pathway development

The Blue Light Project aims to develop responses that require minimal investment by:

- Using existing resources more effectively
- Bringing organisations together and refocusing what they do
- Building bridges with partners including police, housing and social care

Evaluations of several Blue Light Projects have indicated there is potential to reduce demand on services through the provision of this intervention for people with problem alcohol use.

1.4 Delivering the Blue Light Project in Buckinghamshire

The Blue Light Project is being implemented by Buckinghamshire Council and key partners, including health, police, and probation.

The three-year Blue Light Project for Buckinghamshire aims to engage, support and stabilise the most complex clients, to reduce their impact on services and improve pathways and information sharing for this group. Eligibility criteria are set out in Annex B. The key elements of Blue Light in Buckinghamshire are:

- **Delivery**: Assertive Outreach approach led by One Recovery Bucks (ORB), the local specialist Drug and Alcohol service delivered by Midlands Partnership University NHS Foundation Trust, there are two dedicated Blue Light assertive outreach Practitioners.
- **Training**: Specialist and non-specialist staff received Blue Light training from Alcohol Change UK.
- **Multi-Agency Approach**: Development of a Multi-Agency operational Group (MAG).
- **Pathway and Information Sharing**: Development of systems to identify, follow and track individuals through the system to ensure a coordinated approach.
- **Evaluation**: Commissioned to determine the impact and inform future arrangements.
- **Adaptation**: Initially, the model adapted standard Blue Light Project criteria to include those with problem opiate drug use. However, this approach was revised following feedback from ORB to no longer include people who are opiate dependent, due to a rapid access pathway already being in

place for this client group. The Blue Light project remains available to those who use non-opiate drugs alongside their alcohol misuse.

In addition, the following recommendations from the year 1 evaluation were implemented:

- Development of a localised, operational professionals' meetings, led by ORB with Blue Light Practitioners and other agencies that are (or should be) involved in providing support and care to the individual.
- Development of an exit pathway, which includes exit from the Blue Light Project in two ways:
- Exit directly from the Blue Light Project.
- Exit from the project by access onto the standard pathway to continue their treatment journey.

The Blue Light Pathway, shown in the diagram below, is an assertive outreach method for moving **'Positively, Patiently, and Persistently'** with someone across the gap between identification and treatment and beyond. All clients within the Blue Light Pathway are within the Tier 3 element of the treatment service.

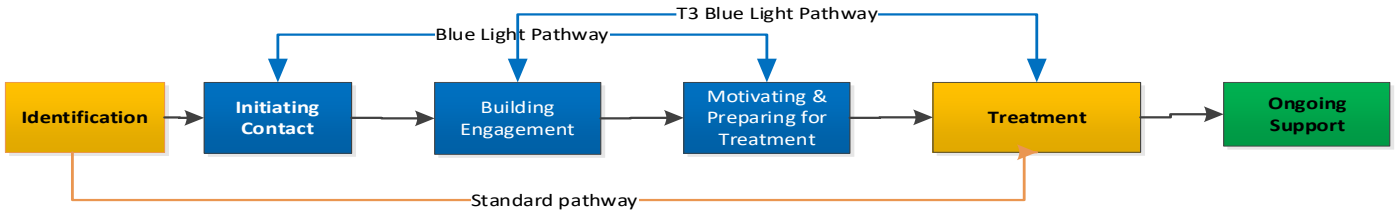

Figure 2: Buckinghamshire Blue Light pathway

1.5 The Task

Buckinghamshire Council commissioned TONIC to undertake a multi-year evaluation of the Blue Light Project in Buckinghamshire. The evaluation aims to:

- Measure impact and effectiveness - using both qualitative and quantitative outcomes.
- Identify success factors and challenges to inform improvements and the future of Blue Light.

1.6 About TONIC

TONIC is a social research consultancy with over 15 years of experience leading central and local government research. TONIC's work focuses on criminal justice, public health, and social care, aiming to improve practice and give a powerful voice to service users, as well as stakeholders, partners, providers, and commissioners in shaping future service design, to inform real-world change. TONIC's research, analysis, insights, and reporting provide a strong evidence base for the decisions that impact many of the most vulnerable groups in society.

This evaluation was conducted by Maria Gallagher (Researcher), Dr Jack Cunliffe (Senior Associate) and Matthew Scott (Managing Director). Find out more about TONIC here: www.tonic.org.uk.

2. Methodology

2.1 Overall Design

The evaluation aims to measure impact and effectiveness using both qualitative and quantitative data to identify success factors and challenges and inform improvements and the future of the Blue Light project.

The evaluation ran from October 2021 to December 2024. The evaluation methods used included: observation of the Multi Agency Group (MAG) meetings; shadowing the specialist Blue Light Practitioners delivering the intervention; document analysis of forms, data capture, policies, and processes; stakeholder interviews with the provider organisation, partner agencies and members of the MAG.

An initial report was produced following the first 12 months of the project.

2.2 Impact Evaluation

The impact analysis took a pre- and post-intervention design, comparing the levels of service use for the clients of Blue Light in the years before and after contact with the service. However, it has a number of limitations.

As only full calendar year data was available for the rates of contact for each of the outcomes, and there was missing data across a number of these outcomes, analysts had to take a pragmatic, parsimonious approach to the analysis.

The impact of Blue Light is only likely to be seen after around 6 months of contact with the project. As such, the decision was made to consider any outcomes reported in the year the client started to be in contact with the service as part of the pre-intervention period, with anything in the following calendar year in the post-intervention period.

The number of years for which data was available in each period (the pre- and post-) was then aggregated, and a yearly service use average for each individual was calculated for each period i.e. the pre and post period. The overall levels in the pre-period and the post-period where then compared, with significance tests conducted using the Wilcoxon signed-rank test.[7]

Due to the pre and post- nature of the analysis, anyone who started on the programme in 2024 was removed from the analysis as no follow up period data was available.

Unit costs (see Annex A) were then applied to each of the domains to allow the total costs in both the pre-intervention and post-intervention periods to be calculated and compared.

[7] This is a non-parametric alternative to the t test for use when the normal distribution of the differences between paired individuals cannot be assumed, as is the case here.

2.3 Qualitative Case Studies

The approach for the qualitative case studies was designed to provide a comprehensive understanding of the impact of the Buckinghamshire Blue Light Project on individual clients. The approach combined in-depth, semi-structured interviews with three key sources: the Blue Light worker, the client themselves, and where appropriate, an external professional involved in the client's care.

TONIC completed these interviews between May – July 2024, some were conducted face-to-face whilst others were facilitated via telephone or Microsoft Teams.

Interviews with Blue Light workers focused on their experiences of delivering support, strategies used to engage and motivate clients, and reflections on the outcomes achieved.

Client interviews provided a first-hand account of their journey through the Blue Light Pathway, including the challenges they faced, the support they received, and their perceptions of its impact on their lives. Input from external professionals, such as healthcare professionals and social workers offered an additional perspective, validating outcomes and highlighting the collaborative efforts central to the project's success.

Once the interviews were completed, the data was triangulated, and key themes were identified. The case studies were then structured using a template collaboratively developed with Buckinghamshire Council.

The template provided a consistent framework for detailing each client's journey through the Blue Light Pathway, including 'Initiating Contact, Building Engagement, and Motivating and Preparing for Treatment'.

3. Findings

3.1 Cohort

During the period October 2021 to May 2024, the Blue Light project received 70 referrals, of which, 44 (62%) were accepted onto the project.

Demographic information

Of the 44 people who commenced the Blue Light project in Buckinghamshire:

- 19 were female (43%) and 25 were male (57%).
- 18 (41%) were resident in Aylesbury at the time of their referral, 12 (27%) were resident in High Wycombe, and 3 (7%) were living in Amersham. 1 person came from each of a number of different areas, including: Beaconsfield, Buckingham, Burnham, Chesham, Gerrards Cross, Haddenham, and Princess Risborough. 3 people (7%) had no fixed abode at the time of their referral.
- 40 (91%) were referred for problem alcohol use with 2 (5%) referred for problem alcohol and non-opiate drug use and 2 (5%) referred for problem opiate use.
- 15 (34%) were referred by ORB, with 15 (34%) referred by Adult Social Care at Buckinghamshire Council, 6 (14%) people referred by Thames Valley Police. 2 referrals came from Probation and 1 each from Aylesbury Vale Housing Trust, Street Warden Team, Fire Service, Housing, Psychiatric In Reach Liaison Team (PIRLS) Oxford Health and the Rough Sleepers Initiative.
- 34 (77%) were known to mental health services.

What outcomes were achieved in Buckinghamshire

Outcomes at closure from Blue Light Project

- 48% (12/25) had a positive outcome including successfully completing treatment on the Blue Light project or transferred to the standard treatment pathway, and are engaging in recovery activities including volunteering.
- 12% (3/25) had a neutral outcome, such as leaving, relocated or rehoused in another Local Authority area.
- 15% (4/25) did not engage with the project having declined the support offer.
- 8% (2/25) were retained in custody.
- 15% (4/25) had died.

Longer term outcomes in relation to the 43% (19/44) still active on the project

A snapshot as of April 2025, indicated:

- 16% (3/19) successfully completed treatment, engaging in recovery activities.
- 84% (16/19) are engaging with the project and are showing more stability, reduced high impact use of public services.

Access to residential rehabilitation

Access to residential rehabilitation in the context of drug and or alcohol treatment should be viewed as a component of the range of services available within the local commissioned drug and alcohol treatment service, and not seen, exclusively, as a final treatment option. As such, residential rehabilitation may be discussed at any stage of the client's journey. Access to residential rehab placement for the right individual at the right time can be a powerful and cost-effective step on their journey to recovery from addiction.

Of the 44 people on the Blue Light Project, 9 (20%) were assessed and supported to access residential rehabilitation. All nine individuals completed the full residential rehabilitation programme, which included successfully engaging in or completing treatment, stabilising and/or reducing their impact on services.

3.2 Activity Levels

Delivery Model

The Assertive Outreach approach involves taking the support to where people are rather than waiting for them to attend the treatment service. This meant interactions took place in homes, cafes, in hospital, on the street, etc.

> "I have found the Blue Light project to be more proactive and supportive than structured treatment." (Blue Light Project Service User)

Blue Light Practitioners worked positively, patiently and persistently with people to build engagement as this takes time, the frequency of contact can range from daily to weekly and can change over time.

> "Blue Light Project has saved me. The support provided and the confidence instilled in me is invaluable. I am now 10 months abstinent from alcohol! I had been in structured treatment multiple times in the past which I was unable to stick to due to the severity of my addiction. I found that the staff were well trained and gave good advice, but I did not find it as helpful as the Blue Light Project. The staff came to my home and gave me good support each week and without this support I would definitely not be where I am now. I am forever grateful that this support was offered to me and would like to add that the staff are amazingly kind, and the care provided was tailored to my specific needs." (Blue Light Project Service User)

Interventions and Care Co-ordination

Blue Light Practitioners delivered a combined total of 2,369 interventions to the 44 people accessing the Blue Light project over the duration of the project from October 2021 up to December 2024. The majority (65%) of appointments and meetings were attended.

Interventions included psychosocial support helping people to care for themselves, safeguarding and mental capacity, harm reduction including nutrition and diet, access to clinical interventions (fibro scan, health checks), access and support for residential rehabilitation, multi-agency professionals meetings and advocacy.

> "I am very impressed with the Blue Light Project. Without the service I would not be where I am today. When I was in the crisis, I was lucky that the project found me. I was so lost, and the support offered to me was critical to my recovery. I found that structured pathway was not personal enough for my recovery as there are no real expectations for this treatment. I did find that the groups were good and the staff that I have met along the way were very supportive, but it was lacking the personal aspects of the Blue Light Project." (Blue Light Project Service User)

Engagement Duration

The average duration people were engaged with the Blue Light project was 14.7 months, although this ranged from a low of 2 months (n=1) to a high of 37 months (n=2).

> "I really want to say that Jodi has been absolutely amazing with all her support. If wasn't for her, I truly know that I would not be where I am. In my eyes, she is a huge bright light at the end of a very long and dark tunnel and for this I can't thank her enough so thank you so much Jodi." (Blue Light Project Service User)

3.3 Impact Evaluation

The benefits of the improved personal experience of people on the Blue Light Project cannot all be quantified but should not be overlooked. Three people on the Project commented on their experience.

> "The Blue Light project has probably partly saved my life to be honest." (Blue Light Project Service User)

> "Blue Light Project is excellent. Much better than the normal service. Dawn is absolutely brilliant, I'm so lucky to have her." (Blue Light Project Service User)

> "Jodi from Blue light is a supportive, kind and helpful person. Without this service, I am not sure I would be where I am today. I am currently 5 months sober and actually able to see a future for the first time in years." (Blue Light Project Service User)

As part of the evaluation, we also sought to identify quantifiable impacts across the cohort of service users. Figures 3 and 4 set out the results of the analysis and present the rates of service use per year across a number of different outcomes.

This analysis found three statistically significant decreases in service demand:

- The number of police crime reports - reduced number of reports prepared after a crime or accident is reported to the Police.
- The number of welfare referrals and calls - reduced calls to Police to conduct checks on an individual's wellbeing or safety.
- The number of presentations to substance misuse services - Sustained engagement with treatment, reduction in crisis referrals into treatment.

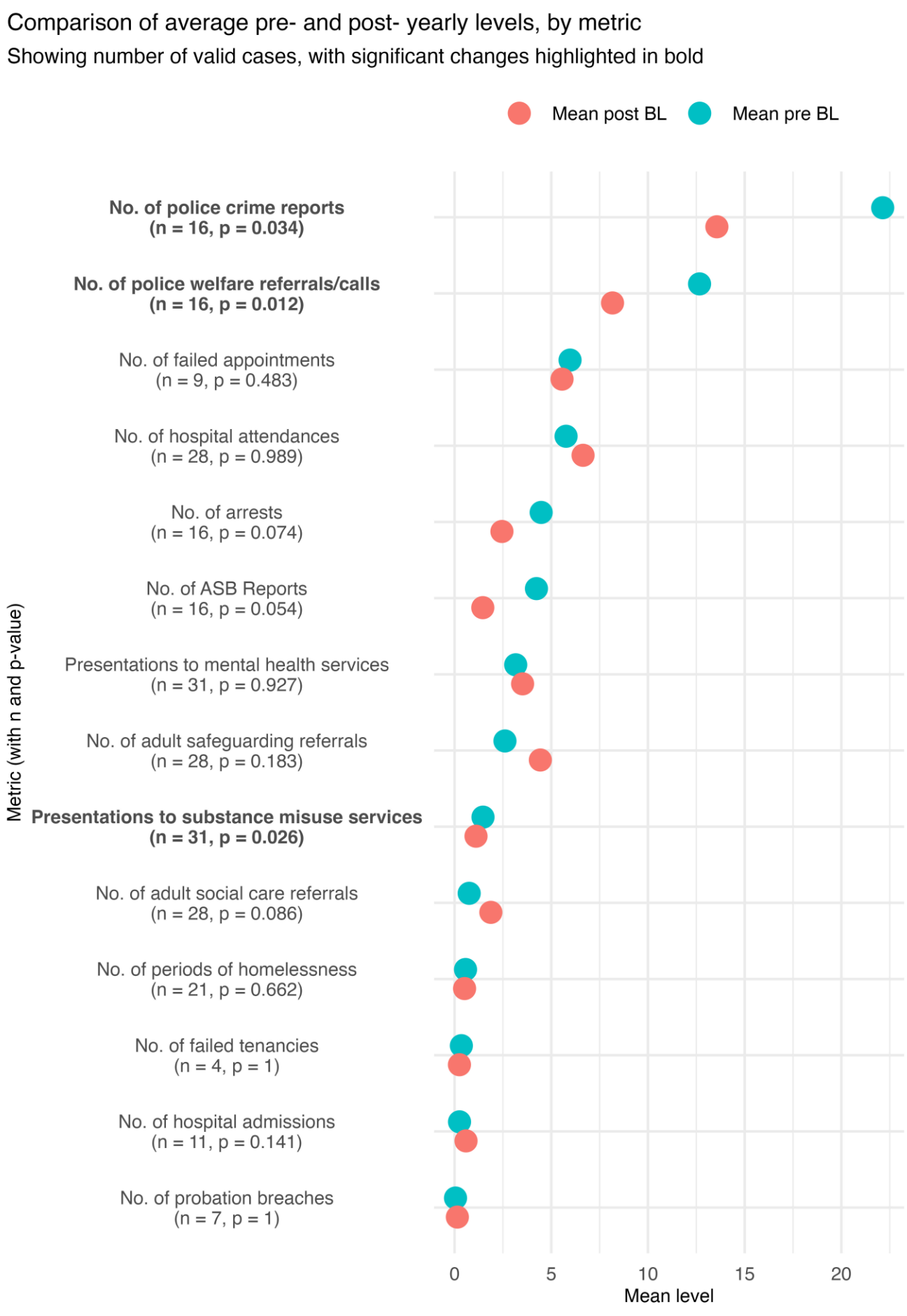

Figure 3: Comparison of average pre- and post-intervention yearly levels, by metric

Table of results

		Mean level per year			
	Valid cases	Pre BL	Post BL	Wilcoxon p value	Difference
Presentations to mental health services	31	3.2	3.5	0.93	Not Significant
No. of adult social care referrals	28	0.8	1.9	0.09	Not Significant
No. of arrests	16	4.5	2.4	0.07	Not Significant
No. of ASB Reports	16	4.2	1.5	0.05	Not Significant
No. of probation breaches	7	0.0	0.1	1.00	Not Significant
No. of police crime reports	16	22.1	13.6	0.03	Significant
No. of failed appointments	9	6.0	5.6	0.48	Not Significant
No. of failed tenancies	4	0.4	0.3	1.00	Not Significant
No. of hospital admissions	11	0.3	0.6	0.14	Not Significant
No. of hospital attendances	28	5.8	6.6	0.99	Not Significant
No. of periods of homelessness	21	0.6	0.5	0.66	Not Significant
No. of adult safeguarding referrals	28	2.6	4.4	0.18	Not Significant
Presentations to substance misuse services	31	1.5	1.1	0.03	Significant
No. of police welfare referrals/calls	16	12.7	8.2	0.01	Significant

Figure 4: Results table by metric

Across other metrics, changes in these service use levels are difficult to detect, due to the size of the sample and the uncertainty with the measures.

However, the direction of travel across the majority of the metrics indicates the utility of the Blue Light project. For example:

- The reduction in the number of arrests from 4.5 in the pre-intervention period to 2.4 in the post-intervention period.
- The number of antisocial behaviour reports falling from 4.2 (pre-) to 1.5 (post-).

Both of these measures fall just outside a significant conclusion, and in cases with such small numbers of participants are indicative of emerging evidence of an effect.

3.4 Cost Differences

Unit costs from (Annex A) were associated with the average service use of each individual in the pre- and post-periods. These were then summed to a total cost of service use per year in both periods where data is available, to give the average total cost per individual.

In the pre-intervention period, the average total cost was £57,200, and the average total in the post-intervention period was £45,100. It is worth noting there was a great deal of variation among the individuals (standard deviation in the pre-intervention period is £52,000 and in the post-intervention period is £39,000). This means the difference is not statistically significant (p-value = 0.107).

The distribution of the costs is displayed in the figure 5 density chart and shows the Blue Light intervention was most effective at tackling those with high initial costs as in the post-period the costs group at a lower level then the pre-period costs.

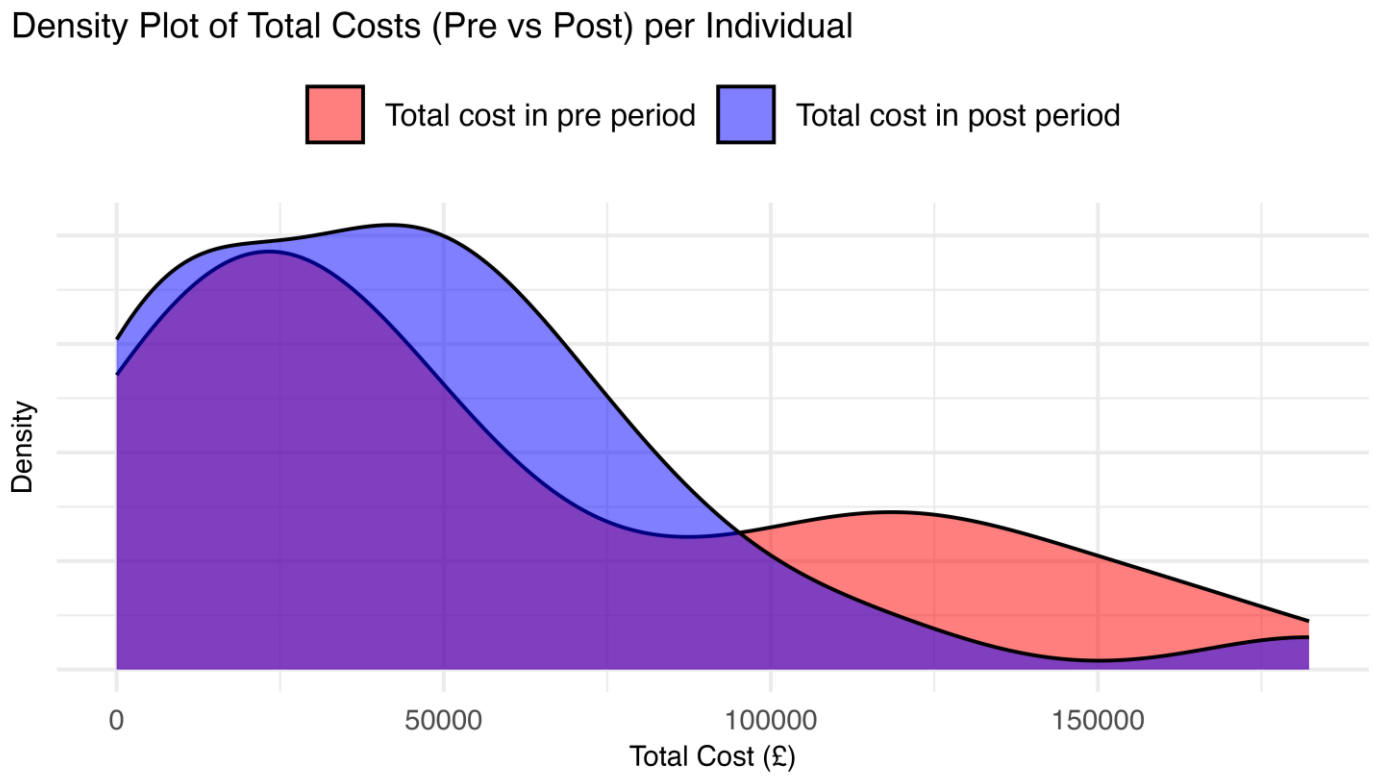

Figure 5: Density plot of total costs (Pre- vs Post-intervention period)

The average yearly total cost of service use where there is data was around £1.89m per year in the pre-intervention period and £1.49m per year in the post-intervention period. This would indicate an average difference of £399,000 per year.

The costs of delivering the Blue Light project varied between £70,000 in 2021-22 to £100,000 in 2023-24 (variations were due to staff vacancies, recruitment and inflation) indicating a potential return on investment of between £4 and £5.70 per £1 spent.

However, due to gaps in the data, the rounding used to allocate service use to pre- and post-intervention periods and the lack of locally agreed unit cost data, this estimate should be treated with caution and is included here to be indicative of the potential for a reduction in costs related to service use.

It is important to note other evaluations of Blue Light Projects in the UK have found evidence of potential savings. Alcohol Concern UK's website notes Blue Light projects across multiple areas have demonstrated evidence of impact, with positive outcomes and cost savings. They particularly cite Lincolnshire, where police incidents involving targeted Blue Light clients fell by 67% after just five months of operation, and Sandwell, where the project resulted in a £150,000 cost saving and a 450% return on investment. Alcohol Concern UK assert evaluations from other areas further support these findings, including reports from Nottingham, Nottinghamshire, Surrey and Medway.[8]

3.5 Qualitative Findings: Case Studies

This section contains six case studies which examine the impact of the Buckinghamshire Blue Light Project on an individual client level. Guided by the principles of moving 'Positively, Patiently, and Persistently,' the case studies focus on the three core elements of the Blue Light pathway: Initiating Contact, Building Engagement, and Motivating and Preparing for Treatment.

The outcomes illustrated include substantial improvements in home environment and accommodation stability, such as securing temporary or long-term housing and reducing homelessness. Significant reductions in drug and alcohol use are documented, alongside improvements in physical and mental health, including enhanced sleep, mood, self-care and diet. The case studies also highlight positive changes in social circumstances, including reduced criminal justice involvement, restored family relationships, and increased participation in social and community activities.

Summary of Findings from the Six Case Studies

The six case studies provide detailed qualitative evidence of the Blue Light Project's positive impact on individuals experiencing high-risk, long-term alcohol dependency combined with complex social, health, and safeguarding needs. Each case demonstrates the effectiveness of the assertive outreach model, delivered with a consistent focus on moving Positively, Patiently, and Persistently across three stages: Initiating Contact, Building Engagement, and Motivating and Preparing for Treatment.

Improved Stability in Housing and Home Environment

Five of the six clients were either homeless, at immediate risk of eviction, or in unsafe and or unstable housing at the point of referral. The Blue Light Project facilitated access to temporary and permanent accommodation:

- Client A secured temporary housing and later relocated to Scotland.
- Client C was rehoused in Aylesbury to improve safety and support access to services.
- Client E secured stable accommodation after rehabilitation, following homelessness and hotel placement.
- Client F was able to provide a stable home, leading to the return of her child from foster care.
- Improvements in living environments were described, including reductions in exploitation (Clients C and E) and chaotic living conditions (Client A).

[8] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project

Reduced Alcohol Use
All six clients reduced their alcohol consumption significantly:

- Clients A, B, C, E, and F went through detoxification and rehabilitation processes, with reports of abstinence at follow-up stages.
- Client D reduced drinking to the point he was no longer alcohol dependent and was discharged from hospital care.

Improved Physical Health
Improved physical health outcomes were noted:

- Client B no longer experienced seizures or numbness and gained weight.
- Client C was able to eat regularly, maintain better physical health, and recover from incontinence linked to alcohol use.
- Client D's fatty liver improved to the extent hospital monitoring was no longer needed.
- Client F became physically healthier after rehabilitation and stopped experiencing hospital admissions related to self-harm and alcohol use.

Improved Mental Health and Emotional Wellbeing
Several clients showed significant improvements in mental health:

- Client F stopped self-harming, stabilised her mental health, and began volunteering.
- Client C overcame depression and anxiety symptoms enough to participate in group activities and engage socially.
- Client E started trauma-informed counselling and re-engaged with his family.
- Clients were supported with medication management (Clients C and F), contributing to improved mood stability and engagement with services.

Reduction in Demand on Emergency and Criminal Justice Services
The Blue Light intervention led to notable reductions in the use of emergency health services and contact with police. Reflections from professionals (e.g., hospital staff, police officers) confirm reduced emergency service demand and highlight relief at having an effective referral pathway for these high-risk individuals:

- Client B had previously presented to A&E up to three times daily and had frequent police and ambulance callouts. Following intervention, he was abstinent, with no further emergency service use.
- Client D had previously generated a high number of police callouts. Following engagement, his drinking was controlled, and there were no further police incidents.
- Client E stopped coming to police attention entirely after engaging with Blue Light and going through rehabilitation.
- Client F had previously been in police cars and ambulances weekly but stopped this pattern post-rehabilitation and abstinence.

Improved Social Relationships and Family Reconnection
Family relationships were restored or significantly improved in multiple cases. These improvements were often cited as serving as key motivators for engagement and sustained behaviour change:

- Client D regained access to his daughter and now sees her regularly.
- Client E reconnected with his mother and sisters with support from his worker and is rebuilding family relationships.
- Client F successfully regained full custody of her young child and improved contact with her older child.
- Client C improved his relationship with his partner and was spending more time with family.

Engagement with Meaningful Activities and Community Support
Several clients progressed to meaningful activity and peer support roles:

- Clients B, C, and F are involved in One Recovery Bucks (ORB), with B and C working towards becoming peer mentors.
- Client F became a volunteer at ORB and started further education and driving lessons.
- Client E now goes to the gym five days a week and is engaging with the community.

The Value of the Blue Light Approach: Professional and Client Perspectives
These key themes were observed by professionals and clients utilising Blue Light:

- **Flexibility and Persistence**: Clients and professionals consistently highlighted Blue Light workers did not give up on people, even when engagement was sporadic or extremely challenging.
- **Holistic, Person-Centred Support**: The service addressed not only alcohol use but also housing, health, social relationships, and practical issues like benefits and advocacy.
- **Bridging the Gaps**: Professionals acknowledged Blue Light fills a critical gap for individuals who do not engage with traditional treatment pathways. The assertive outreach model, characterised by patience and persistent contact, was cited as essential in enabling engagement where other services had struggled.

Conclusion from the case studies
The Blue Light Project has demonstrated clear benefits for individuals with complex needs and long-term alcohol dependency. Through persistent and holistic outreach, the project achieves outcomes in reduced alcohol consumption, improved physical and mental health, housing stability, reduced emergency service demand, and enhanced social and family relationships.

The evidence from these case studies highlights the Blue Light Project's critical role in reducing harm, improving lives, and supporting system-wide efficiencies by alleviating pressure on emergency health, social care, and criminal justice services.

The Six Case Studies

The following pages contain the detailed case studies.

CASE STUDY A

Date	Date of case study interview: 07/05/2024 Date of contact data, accurate as of: 10/12/24
Submitted by (Name & Role)	MG (Researcher and Analyst, TONIC) & JH (Blue Light Worker, One Recovery Bucks)
Client	A (female, 42)

Initiating Contact

How did the client come into contact with the Blue Light Project?

A was nominated to the Blue Light project in July 2023 by adult social care. A eventually engaged with the project in November 2023.

Brief overview of the client's background. What were their needs at the start of the project?

A experienced various adverse childhood experiences[9] (ACEs) such as domestic abuse and substance use when she was a child. A used alcohol throughout her childhood, both at home and at school, contributing to her becoming alcohol dependent.

As an adult, A was a victim of domestic abuse. Her partners would exploit her vulnerability and use alcohol for coercive control. A experienced homelessness and was repeatedly admitted to hospital throughout this time, where she would often discharge herself.

Building Engagement

Building engagement with A took 14 contacts over a 4-month period. Contacts included face to face contact, telephone calls, home visits etc. In addition, over the same period the Blue Light Practitioner had 5 separate contacts with professionals to coordinate support for A.

The Blue Light team conducted home visits between July and November 2023 with the aim to engage A. No one would answer the door throughout this time, however the team kept returning. A's partner was abusive and would try to prevent support services from accessing the property[10]. A also had suspected undiagnosed learning difficulties, which made it difficult for her to communicate with professionals.

> "Throughout that time when we were trying to engage A, her partner would try and stop us, he would always try and put barriers up. He would tell her that we were bad people who were going to grass her up" (Blue Light Worker

[9] Adverse childhood experiences (ACEs) are potentially traumatic events that can happen to children between the ages of 0 and 17. They can have long-term negative effects on a person's health, well-being, and opportunities.

[10] Domestic abuse perpetrators can be very adept at manipulating professionals and agencies and may use a range of tactics to prevent contact with victim.

What intervention did the client receive? What support was provided?

The Blue Light team supported A to complete a homeless application and found her temporary accommodation. Throughout this time, A's alcohol use increased, and her physical and mental health deteriorated. She would refuse to eat anything, despite the Blue Light team providing her with food parcels.

> "When we would visit, A would be laying in her own excrement, surrounded by bottles and cans. I remember taking away 40 or 50 cans one day to put in the rubbish for her. She was ordering her alcohol through Deliveroo, so it was really difficult to understand how much she was drinking." (Blue Light Worker)

The Blue Light team completed multiple safeguarding referrals and would **visit the property** twice a week and speak to A daily on the phone. A was allocated a social worker and was supported by a domestic abuse support service.

A's Blue Light worker went to visit A in December 2023, where A appeared to be jaundiced or be showing signs of alcohol related liver disease[11]. A refused to go to hospital, however the paramedics' assessment of her was that she could not make decisions related to her physical health, so was taken to hospital anyway. The hospital stated A had extremely low sodium levels. Despite this, A discharged herself from hospital the same day.

The Blue Light worker went back to visit the property, spent multiple hours talking to A and encouraged her to go back to hospital. The Blue Light worker **communicated with the hospital and police staff** throughout this time. Eventually, A went back to hospital, stayed there and had a detox. The Blue Light worker made sure the hospital did not discharge A until a housing plan was put in place.

A was admitted to a specialist unit which provides short-term care for those waiting for additional support arrangements. A stayed for 57 days and the Blue Light team visited regularly.

During this time, **the Blue Light team worked to find a rehabilitation placement**. When A left the specialist unit, she had a lapse[12]. Due to this, the rehabilitation clinic would not accept her. **The Blue Light team organised temporary accommodation at a hotel**. A was asked to leave due to disruptive behaviour, such as exposing herself to staff whilst intoxicated. A went back to hospital and they agreed to admit her until the Blue Light team could take her to the rehabilitation clinic. This was to ensure there was no risk of relapse[13].

> "This only happened because of the positive relationships and communication we have with the hospital and other professionals. At one point there was 10 professionals in an email thread related to A. The relationships with other professionals have been so important in our roles." (Blue Light Worker)

Due to her complex needs, **The Blue Light team travelled to the rehabilitation clinic with A to support her through the admission process.**

[11] According to the NHS website, "Jaundice is when your skin or the whites of your eyes turn yellow. It can be a sign of something serious, such as liver disease". https://www.nhs.uk/conditions/jaundice/

[12] A lapse refers to a short return to alcohol or other drug use. It is a one-time (or temporary) step back on a recovery journey.

[13] A relapse refers to a return of alcohol or other drug use, which someone has previously managed to control or quit completely. In a relapse the use of alcohol or other drugs goes back to previous levels of use, or close to this.

Motivating and Preparing for Treatment
A went to rehabilitation with support from the Blue Light team but relapsed after she left. She later **returned to rehabilitation**, which was a choice she made herself. During this time, the Blue Light team supported her with accessing **legal advice** related to the property which she owns with her partner. At the time of writing this case study, A is now **abstinent** and has relocated to Scotland.

Keyworker/Professional Reflection and Learning

Professional: Social Worker, Adult Social Care

What do you believe the impact of the Blue Light Project has been on this client?

The social worker said:

> "A was very hard to engage at the start. The Blue Light Project was able to work closely with her and give her a really strong support system which was valuable particularly because she was very reliant on other people. Having someone specific and easily available for her was helpful."

What is the added value of the project?

The social worker said:

> "Getting people to engage that don't usually engage. The Blue Light Project has the time and the resource to focus on rapport building which is amazing."

CASE STUDY B

Date	Date of case study interview: 07/05/2024 Date of contact data, accurate as of: 10/12/24
Submitted by (Name & Role)	MG (Researcher and Analyst, TONIC) & DB (Blue Light Worker, One Recovery Bucks)
Client	B (male, 57)

Initiating Contact

How did the client come into contact with the Blue Light Project?

B was nominated to the Blue Light Project in May 2023 by the Adult Social Care Team at Buckinghamshire Council. This was due to being a risk to himself and the public. There were multiple concerns raised by adult social care such as disorderly behaviour when intoxicated, known to have attempted suicide and known to carry weapons, resulting in numerous police and ambulance call outs.

Brief overview of the client's background. What were their needs at the start of the project?

B had been known to ORB and was 'in and out' of structured treatment 17 times, since 2017[14]. B was being admitted to hospital daily due to his alcohol dependence and epilepsy. He would have regular contact with the police as he was violent and aggressive to members of the public after having a seizure. Due to the volume of alcohol B was consuming, he was struggling to take his prescribed medication for epilepsy and his mental health. B was also experiencing numbness in his extremities, which can be associated with alcohol use. B had a flat in the local area but never stayed there. He would shower at service stations as he could not afford gas or electricity. When he was first nominated to the Blue Light Project in May 2023, he was drinking around one litre of vodka a day.

Building Engagement

Building engagement with B took 14 contacts over a 5-month period. Contacts included face to face contact, telephone calls, home visits etc. In addition, over the same period the Blue Light Practitioner had 14 separate contacts with professionals to coordinate support for B.

When B was nominated to the Blue Light Project, he was very difficult to locate. He would often walk for miles and never stayed at the same address. The Blue Light worker used their initiative to contact local hospitals to find B's next of kin. Eventually, the worker managed to find B and asked him to come into ORB for an appointment.

B used to struggle keeping appointments. To manage this, the Blue Light worker would schedule their meetings for the same time every week. The Blue Light worker took time to build rapport and trust with B. He reported enjoying having a consistent worker.

> "It was really difficult for us to locate him when he was nominated to Blue Light. He used to walk for miles and miles. I rang around a few hospitals, found out who his next of kin was, and

[14] This is referring to the 'revolving door cycle' where some people are stuck and repeatedly present to the treatment service. Clients may be ambivalent about recovery or engaging in the service for other reasons e.g. access to detox.

managed to find him. He was staying with a relative in Liverpool. I asked him to come into ORB and see me." (Blue Light Worker)

"It was more likely he would remember to come to the appointments if it was the same time each week. I made an effort to schedule our meetings for 12pm every Friday." (Blue Light Worker)

What intervention did the client receive? What support was provided?

The Blue Light worker would **meet with B weekly** and facilitate telephone calls. In addition, the Blue Light worker would **communicate with other professionals** involved in B's care. For example, the worker would know which appointments B would have to attend during the week and remind him to go.

"I had to communicate to B that he wasn't going into the recovery cafe today and only coming into his appointment with me. I promised to still give him food to takeaway, but I had to put these boundaries in place with him." (Blue Light Worker)

Motivating and Preparing for Treatment

B's goal was to go to a rehabilitation clinic. To achieve this, the Blue Light worker **communicated with the local hospital to organise a detoxification**. It was difficult to get B to engage at this point as he kept discharging himself from hospital. The Blue Light worker had to keep communicating with the hospital to advocate for B to keep his bed on the ward. In addition, the worker kept in **constant communication with B and outlined the expectations** for him to remain in hospital to complete the detoxification. Eventually, B remained in hospital, completed the detoxification and was taken to a rehabilitation clinic.

"When he was in hospital having the detox, we brought him some clean clothes and hygiene packs, because he had absolutely nothing." (Blue Light Worker)

"It was very challenging when he kept discharging himself. It was 3 times in 3 days. The hospital were saying they were unable to keep him a bed if he's not staying in it. I had to communicate with B and explain he wouldn't be able to go to rehab if he didn't stay in hospital. He eventually went back and stayed there." (Blue Light Worker)

Whilst in rehabilitation, the Blue Light worker had telephone appointments with him once a week. The Blue Light team made the decision to keep B on the Blue Light pathway after he left the rehabilitation clinic, to ensure continuity of care. They worked on creating an aftercare plan alongside B to ensure he was prepared. This involved **communicating with a local charity organisation to arrange for white goods to be delivered to his property**. They also made plans to **apply for Personal Independence Package (PIP)** and build on B's good local connections with churches and community organisations.

B has now left rehabilitation, is abstinent and has joined the Recovery Network at ORB, where he is working towards being a peer mentor. B is **no longer suffering with seizures** and numbness in his extremities. He is **sleeping and eating regularly**, has gained weight and is continuing to prioritise his physical and mental health.

"B looked like a completely different person when I went to go and visit him in rehab. He was clean, gained weight, he had started making friends. He was being accountable for his actions." (Blue Light Worker)

"We are going into the fifth week of abstinence now. There have been no police or ambulance call outs. He eats 3 meals a day and is taking his medication. This is someone who was very high risk and was being admitted to hospital almost daily." (Blue Light Worker)

Keyworker/Professional Reflection and Learning
Professional: Alcohol Team, Wexham Park Hospital **What do you believe the impact of the Blue Light Project has been on this client?** The alcohol team worker said: "B had been presenting at the emergency department, almost 3 times a day. The Blue Light Project really made a difference. Without Blue Light, I don't think B would be in rehab right now. Most likely he would be still presenting at hospital." **What is the added value of the project?** The alcohol team worker said: "The support is more holistic. All the professionals were involved in planning B's care." "Before the Blue Light Project became involved with B it felt like there was nothing we could do. We would manage him at the hospital and then he would be back the next day. It felt like our support was not enough. When the Blue Light Project became involved, I felt very relieved." **Any reflections or learning from working with this client?** The alcohol team worker said: "The Blue Light Project is now a big help to us at the hospital. We now have an option to refer patients who are chaotic and need support."

CASE STUDY C

Date	Date of case study interview: 07/05/2024 Date of contact data, accurate as of: 10/12/24
Submitted by (Name & Role)	MG (Researcher and Analyst, TONIC) & JH (Blue Light Worker, One Recovery Bucks)
Client	C (male, 45)

Initiating Contact

How did the client come into contact with the Blue Light Project?

C was nominated to the Blue Light project in April 2022 by a housing provider due to his alcohol use and multiple suicide attempts.

Brief overview of the client's background. What were their needs at the start of the project?

When C engaged with the Blue Light Project, he was drinking up to 55 cans of beer a day. He struggled with his home environment as he was living on an estate surrounded by people who used substances. C had no social life, he spent the day standing in his kitchen, drinking alcohol and looking out of the window. He would hardly eat any food throughout the day apart from occasional snacking.

C suffered with poor mental health, specifically depression and anxiety. He would self-harm and was known to attempt suicide. Due to the amount of alcohol, he was consuming, the medication prescribed for his mental health was not taking effect. C was incontinent and experienced alcohol-related seizures, so he had to leave his job as a chef.

> "C would never eat anything, that was a big thing at the start, He loved cooking but had to stop because of the seizures and was probably fearful of cooking. We had long conversations about meal planning, for example making a sandwich in advance and leaving it in the fridge to eat later." (Blue Light Worker)

Building Engagement

Building engagement with C took 2 contacts over a 3-week period. Contacts included face to face contact, telephone calls, home visits etc.

The Blue Light team **conducted home visits** at the start to engage C. This worked well and after some time, C felt confident to come to into One Recovery Bucks for appointments.

> "C was quite lonely, and it took a while to build a rapport, but we got there in the end. We would try to build a routine. So, one week I would go out and see him and the next week he would come to Aylesbury to see me. I think that worked well." (Blue Light Worker)

What intervention did the client receive? What support was provided?

The Blue Light team took time to **create an alcohol reduction plan** with C, structured around drink diaries. In 6 months, C reduced his alcohol consumption, so he was only drinking 5 litres of cider a day.

They also worked on **establishing a routine** for C which involved him meal planning and coming into the One Recovery Bucks service.

The Blue Light team **facilitated numerous multi-disciplinary team (MDT) meetings** with professionals to improve C's home environment and prevent him from being exploited. They advocated for C to move to Aylesbury to be closer to the service.

They also **organised GP appointments** for C and attended with him to support and communicate his needs. This enabled C to change his mental health medication and have a personal alarm that would remind him to take it.

> "I made the GP appointments and attended with him quite a few times, I was able to explain his low mood. I also provided him with a dossette box, so every time I went round, we would plan his medication for the week." (Blue Light Worker)

Motivating and Preparing for Treatment

The Blue Light team supported C to go to a detoxification unit, which they drove him to, and he is now 3 months abstinent.

C is now abstinent and in **structured treatment** at One Recovery Bucks. His Blue Light worker facilitated joint appointments with the staff to allow them to build a rapport before starting treatment. C is much more **sociable** and engages in groups at the service, he is also interested in training to be a peer mentor.

C is now able to **meal plan** and eats regular substantial meals. C moved into **new accommodation** in April 2023, supported by the Blue Light team, and is much safer and happier.

> "At the start he didn't have any confidence. Now, every day C is going out and doing his weekly shopping, which is a big step, he would never do that usually. He's also joining groups and getting involved." (Blue Light Worker)

Client Testimonial

What is the best thing about the Blue Light Project?

The client said:

> "My keyworker. She was there with me from the start and put me on the right track. If it wasn't for her, I wouldn't have done it." (Blue Light Client)

What changes have you noticed in yourself since being supported by the Blue Light Project? What has been the impact of the support?

The client said:

"I'm now working on decorating my new home. Me and my partner are getting on much better. I see my family more. It's all going really well. It's been life changing. ORB is like my second home, I love going in and seeing the workers and spending time with people in a similar situation." (Blue Light Client)

CASE STUDY D

Date	Date of case study interview: 07/05/2024 Date of contact data, accurate as of: 10/12/24
Submitted by (Name & Role)	MG (Researcher and Analyst, TONIC) & JH (Blue Light Worker, One Recovery Bucks)
Client	D (male, 40)

Initiating Contact

How did the client come into contact with the Blue Light Project?

D was nominated to the Blue Light Project by the police in April 2022. This was because of his demand on the service due to his alcohol use.

Brief overview of the client's background. What were their needs at the start of the project?

D was placing a huge demand on the police due to his alcoholism. He was described as making a large number of phone calls to the police whilst intoxicated. D was being monitored by a neighbourhood patrol team because of the large number of police call outs.

D was unemployed because he had lost his job as a mechanic due to his alcohol use. This caused financial difficulties such as D getting into debt, which was impacting his mental health. He was also unable to see his daughter because of his chaotic behaviour.

D had an enlarged stomach and fatty liver. The hospital had told him he needed to reduce his alcohol consumption to prevent serious damage to his organs.

Building Engagement

Building engagement with D took just 1 contact over a 2-week period. Contacts included face to face contact, telephone calls, home visits etc. In addition, over the same period the Blue Light Practitioner had 3 separate contacts with professionals to coordinate support for D.

What intervention did the client receive? What support was provided?

The Blue Light worker organised to visit D at his property. They worked together to **build a plan towards controlled alcohol use** because D didn't want to stop drinking. His goal was to **find employment** so he could earn money and pay off debt, which was affecting his mental health. D eventually found a job and the Blue Light worker would visit him during his lunch break.

"I had to explain to D that the core issue was his alcohol use, but surrounding this was lots of different factors like debts and children. I was there to support him with fixing these other things in order to address his alcoholism." (Blue Light Worker)

After taking time to build a rapport with D, the Blue Light worker identified the importance of seeing his daughter. They **worked alongside social care** and a family mediator to advocate for D to see his daughter by communicating his efforts to become abstinent. The Blue Light worker would provide encouragement by gently **prompting D to attend appointments** or make phone calls to social care. The worker also motivated D to organise a meeting with the school to arrange contact with his daughter.

"There were lots of barriers that had been put in place to stop D from seeing his daughter, he wasn't allowed to have her overnight. Once he was abstinent or controlled drinking, there was no risks there that should have stopped him from seeing her. We worked together with social care and a mediator to support him seeing his daughter. This really gave him the encouragement to work full time." (Blue Light Worker)

"D needed prompts and guidance. I would remind him to ring the social worker or go to the school and meet with the headteacher. I tried to encourage him to stand up for himself to be able to see his daughter, because I knew it was affecting him and how much he wanted to be involved in her life. After he had the meeting with the headteacher, he came to see me, he was dressed in a suit and he was really proud of himself." (Blue Light Worker)

Motivating and Preparing for Treatment

D has learnt to **control his drinking** and is no longer alcohol dependent. Due to the reduction in alcohol consumption, the **hospital has discharged him** as they no longer have concerns about his fatty liver. D is now **working full time** as a mechanic and is able to see his daughter on a Sunday. There are now **no call outs** to Blue Light services.

D has been discharged from the Blue Light Project and declined recovery support. The rationale for this was due to his controlled drinking and reduction in police call outs.

CASE STUDY E

Date	Date of case study interview: 07/05/2024 Date of contact data, accurate as of: 10/12/24
Submitted by (Name & Role)	MG (Researcher and Analyst, TONIC) & JH (Blue Light Worker, One Recovery Bucks)
Client	E (male, 41)

Initiating Contact

How did the client come into contact with the Blue Light Project?

E was already known to ORB before being nominated to the Blue Light Project in January 2022. His Blue Light worker had previously supported him as an outreach worker so had already established some trust and rapport.

Brief overview of the client's background. What were their needs at the start of the project?

E had experienced severe trauma during his childhood, such as physical violence and domestic abuse.

E has 2 children but was unable to see them due to chaotic behaviour and alcohol consumption. He was living in temporary accommodation but was evicted due to his alcohol use and made homeless. E had injunction orders in two town centres in Buckinghamshire. He was in prison for 2 weeks before being nominated to the Blue Light Project. He was described as very high risk due to his conviction history.

Building Engagement

Building engagement with E took 2 contacts over a 4-day period. Contacts included face to face contact, telephone calls, home visits etc.

E would spend his time drinking alcohol in dark alleyways. The Blue Light worker would go and **visit E multiple times a week in the community**.

Motivating and Preparing for Treatment

E wanted to go to a rehabilitation clinic. Due to his conviction history, homelessness and risk level, the clinic was hesitant to accept him. The Blue Light worker **advocated for E and communicated his situation and complex needs** to the rehabilitation clinic.

Before going to the rehabilitation clinic, the Blue Light worker **organised and facilitated multiple meetings with the housing team** to try and find E accommodation for after rehabilitation.

Eventually, the clinic agreed to accept him. The Blue Light worker **drove him to the rehabilitation clinic** and supported him with the admissions process. E was at the rehabilitation clinic for 3 months and was given the role as 'Head Gardener.'

"I try to drive all of my clients to rehab or at least go with them. I think it's important they go with someone who they respect." (Blue Light Worker)

E wasn't housed straight after leaving rehabilitation, due to a shortage in accommodation. However, he was funded a room in a hotel whilst he waited.

In the time after leaving rehabilitation, E had a few lapses. Despite this, E is now able to **control his alcohol consumption** and all previous calls to **police and ambulance services have stopped**. E was offered structured treatment at ORB but didn't want to engage. He is currently being **supported by an outreach worker at ORB**.

"Structured treatment is very different to the Blue Light pathway. In treatment, you complete a lot of workbooks, you're expected to come into the service, and you're often expected to attend groups. On the Blue Light you tailor the plan to the client because they're too chaotic." (Blue Light Worker)

E is practicing more **self-care** and now goes to the gym 5 days a week using a membership that his Blue Light worker helped him find.

"I knew E was interested in going to the gym and exercising. I found him the gym membership and asked whether they would offer him a discounted rate after explaining his situation and they agreed." (Blue Light Worker)

E is now living in stable accommodation and has started to engage with a mental health team and is receiving trauma-informed **counselling.** In addition, E is **rebuilding a relationship with his family**. The Blue Light worker facilitated phone calls with his Mum and sisters and supported them to write supporting statements for E's rehabilitation application.

"I organised phone calls with his Mum and sisters before he went to rehab. He had minimal contact with them and they didn't believe he was actually going to change." (Blue Light Worker)

Keyworker/Professional Reflection and Learning

Professional: Thames Valley Police

What do you believe the impact of the Blue Light Project has been on this client?
The Thames Valley Police staff member said:

"The Blue Light project had a huge effect on E. When he started to engage, there was a very obvious effect in his behaviour. He did not come to any police attention at all, and on speaking to him he was sober, happy, polite and he was very cooperative and friendly. It was obvious that he was trying to turn a corner."

What is the added value of the Blue Light Project?
The Thames Valley Police staff member said:

"The Blue light Project is superb as it gives vital support and guidance to the people that are proposed to the scheme. It is an additional layer of support that can be offered to people in

addition to regular mainstream support. I feel more comforted when I hear that people are on the scheme as it shows that they are engaging and there is a high chance of long term behaviour changes."

Any reflections or learning from working with this client?

The Thames Valley Police staff member said:

"The experience of Blue Light with E has been very good. I think it is a hugely beneficial initiative that has clearly produced superb results. E engaged well with the initiative which showed it was a success."

CASE STUDY F

Date	Date of case study interview: 25/07/2024 Date of contact data, accurate as of: 10/12/24
Submitted by (Name & Role)	MG (Researcher and Analyst, TONIC) & LF (Operations / Safeguarding and Complex Needs Manager, One Recovery Bucks)
Client	F (female, 36)

Initiating Contact

How did the client come into contact with the Blue Light Project?

F's first appointment with the Blue light Project was in October 2021, following a nomination from ORB due to high-risk long term alcohol use. During her first home visit, Fs environment was observed to be clean and tidy and F was alcohol-free following her detoxification.

Brief overview of the client's background. What were their needs at the start of the project?

F had been in abusive relationships throughout her life, starting with her father as a child. F has a diagnosis of Emotionally Unstable Personality Disorder and often described hearing voices telling her to self-harm.

F had two children but due to her lifestyle her young child was placed into temporary foster care and was allowed monthly visits in a contact centre. Her teenage child lived with their father.

F was admitted to hospital in September 2021, following a suicide attempt. She was later admitted to a mental health facility and medically detoxed from alcohol.

Building Engagement

Building engagement with F took 3 contacts over a 1-month period. Contacts included face to face contact, telephone calls, home visits etc. In addition, over the same period the Blue Light Practitioner had 4 separate contacts with professionals to coordinate support for F.

Following her initial appointment, F disengaged with the Blue Light Project for a short period of time. **Efforts were continued** and **engagement was reestablished** in December 2021, in the form of home visits. F had relapsed on alcohol and was drinking 56 units of alcohol per week. F also had history of cocaine use but she was abstinent at this point for 12 months. Engagement with F at this time was sporadic as she would often cancel appointments. In December 2021, the Blue Light worker facilitated a phone conversation, in which F stated she would like to be considered for residential rehabilitation due to her alcohol use increasing over the month.

Motivating and Preparing for Treatment

In January 2022, a **case discussion was facilitated by the Blue Light team** regarding residential rehabilitation. Following this, a rehabilitation application was completed to be heard at panel for approval.

Engagement with the Blue Light Project continued following this in the form of **home visits and telephone calls** to continue to prepare F for rehabilitation. During an appointment, F disclosed she had been arrested and was facing criminal charges, she was also continuing to drink alcohol and self-harm. Her son had been placed in long term foster care with the prospect of being adopted out of her care indefinitely.

Following her son being placed into long term foster care, F's attendance became sporadic once again and attempts were made to reengage her in the project. During this time, F was approved funding for residential rehabilitation and the process begun to find F a suitable placement. F's alcohol use continued to increase resulting in a seizure. F also relapsed on cocaine and her self-harming behaviours increased.

In March 2022, F went to court following her previous arrest and was issued a fine. She was told this could have been custodial had she not been accepted for residential rehabilitation, with the support of the Blue Light Project.

Throughout March 2022, F's alcohol use and self-harming continued to increase, with her physical health declining. Due to the increase in self-harm, the rehabilitation that was chosen to best support F would not accept her until August 2022 as they needed a period of time where she had stopped self-harming.

F continued to engage on the project through home visits and phone appointments. Her detoxification application was completed in April 2022.

Her engagement with the Blue Light Project continued however hospital admissions were ongoing throughout July 2022 due to self-harm increasing. During this time, the **Blue Light Worker was offering support up to 3 times a week**.

In August 2022, F stated that she was 15 days alcohol free. She also disclosed that she had been placed in a mental health facility for a period of time in July due to the severity of her self-harming. F described this as the 'wakeup call' she needed and claimed she was ready to focus on rehabilitation. The Blue Light worker **supported her with an application to an alternative rehabilitation** due to the previous placement being unable to accept F based on recent self-harm.

In September 2022, F was taken to residential rehabilitation for a 12 week placement.

Following residential rehabilitation, F came back into service and continued to engage at ORB until November 2023.

F has **remained abstinent** and now is a **volunteer** supporting new service users coming through to ORB. She had to be closed with the service to start the application process to be a volunteer at ORB.

F began her Maths qualification through **adult learning** and started driving lessons. She accesses **mutual aid** weekly and her mental health is now stable with **no self-harming episodes**.

The Blue Light team enabled F to work with **children's social care** which has resulted in her son being returned to her care full-time.

Client Testimonial

What is the best thing about the Blue Light Project?

The client said:

> "My workers were kind and non-judgmental. I think there's a lot of people in addiction that are in isolation and scared to actually go to a centre. The fact they come to your house and you're able to talk to someone in your own living room, is good for some people. In normal treatment, if you don't show up for a few weeks, you get discharged. The Blue Light project doesn't give up on you like that. (Blue Light Client)

What changes have you noticed in yourself since being supported by the Blue Light Project? What has been the impact of the support?

The client said:

> "The Blue Light project saved my life. I was a really bad self-harmer. I was in police cars and ambulances every week. Now I'm out of rehab and I'm working as a volunteer at One Recovery Bucks, I want to eventually be a recovery worker. I'm also fighting to get my little boy out of foster care and it's looking like he might be able to come home." (Blue Light Client)

Annexes

Annex A – Unit Costs

Unit / Metric	Local Data Owner	Description & Source	Link to Source Data	Original Unit Cost (at time the source data was published)	Revised for inflation[15]
Adult social care referrals	Buckinghamshire County Council	Unit cost estimate of referral only	Martin-Stevens-Costs-and-outcomes - https://www.ilpnetwork.org/wp-content/media/2016/10/Martin-Stevens-Costs-and-outcomes.pdf	£360	£466.90
Adult safeguarding referrals	Buckinghamshire County Council	Unit cost estimate of referral only	Martin-Stevens-Costs-and-outcomes - https://www.ilpnetwork.org/wp-content/media/2016/10/Martin-Stevens-Costs-and-outcomes.pdf	£360	£466.90
Presentations to substance misuse services (Episodes of Care)	Inclusion (part of Midlands Partnership University NHS Foundation Trust)	Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE Clinical Practice Guidance 115), p.408	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£2,334	£2,503.73
Welfare referrals/Calls (Police)	Thames Valley Police	Greater Manchester Combined Authority (GMCA) Research Team + NAO Analysis, based on CIPFA, Home Office, Ministry of Justice and Youth Justice Board Data.	NAO - The cost of a cohort of young offenders to the criminal justice system. 2011 https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/	£1,132	£1,214.32
Police crime reports	Thames Valley Police	Greater Manchester Combined Authority (GMCA) Research Team + NAO Analysis, based on CIPFA, Home Office, Ministry of Justice and Youth Justice Board Data.	NAO - The cost of a cohort of young offenders to the criminal justice system. 2011 https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/	£1,132	£1,214.32
Arrests	Thames Valley Police	"Field, S., Flows and Costs in the Criminal Process, unpublished document, Home Office, 1997 HM Treasury, Public Expenditure Statistical Analysis, 2000–01, CM 4601, 2000. Home Office, Statistics on Race and the Criminal Justice System, 1998, 1999"	Family Savings Calculator - Department for Education	£2,241	£4,025.05
ASB Reports	Thames Valley Police	The Economic and Social Costs of Anti-Social Behaviour: a review' (London School of Economics and Political Science, 2003), p.43	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£780	£836.72
Probation Breaches	Probation	*Probation Trust Unit Costs* *Financial Year 2011-12 (revised)* *National Offender Management Service* *Ministry of Justice* *Information Release*	https://assets.publishing.service.gov.uk/media/5a7c2e4240f0b674ed20f588/probation-trust-unit-costs-tables-11-12.pdf	£2,640	£3,588.00
Probation Failed appointments	Probation	*Probation Trust Unit Costs* *Financial Year 2011-12 (revised)* *National Offender Management Service* *Ministry of Justice* *Information Release*	https://assets.publishing.service.gov.uk/media/5a7c2e4240f0b674ed20f588/probation-trust-unit-costs-tables-11-12.pdf	£255	£346.57

[15] Update the original unit cost figure to 2023 values using the Bank of England's inflation calculator https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

Unit / Metric	Local Data Owner	Description & Source	Link to Source Data	Original Unit Cost (at time the source data was published)	Revised for inflation[16]
Period of homelessness	Housing	Mapping severe and multiple disadvantage (Lankelly Chase Foundation, 2015), pg.42	https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf	£26,814	£28,763.91
Failed tenancies	Housing	Eviction cost - Based on Manchester City Council analysis s from Eastland Homes	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£8,518	£9,137.43
999 call outs (ambulance)	BHT & Wrexham Park Hospital	National Cost Collection: National Schedule of NHS costs - Year 2020-21 - NHS trust and NHS foundation trusts (weighted average of values against HRG code, sheet AE VB01Z to VB99Z)	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£334	£358.29
Hospital attendance (ED / A&E)	BHT & Wrexham Park Hospital	National Cost Collection: National Schedule of NHS costs - Year 2020-21 - NHS trust and NHS foundation trusts (weighted average of values against HRG code, sheet AE VB01Z to VB99Z)	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£306	£328.25
Hospital admission	BHT & Wrexham Park Hospital	National Cost Collection: National Schedule of NHS costs - Year 2020-21 - NHS trust and NHS foundation trusts (weighted average of values against HRG code, sheet AE VB01Z to VB99Z)	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£3,030	£3,250.34
Presentations to mental health services (previous episodes of care within Mental Health Team, e.g. Street Triage Team, CMHT, Whiteleaf)	Oxford Health	Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008), p.118, 25, 40, 59, 74, 96, 104-109 and 114	Greater Manchester Cost Benefit Analysis: Technical Specification (Version 1.0, January 2011)	£2,530	£2,713.98

[16] Update the original unit cost figure to 2023 values using the Bank of England's inflation calculator https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

Annex B – Eligibility Criteria

The Buckinghamshire Blue Light Project Multi-Agency Group members will be individually responsible for bringing information about identifying the change resistant drinkers and/or drug users their organisation has nominated so the individual can be discussed by the MAG. A single definition of this client group is not possible, and inclusion is at the discretion of the Chair of the meeting. However, the people identified by agencies for joint management by the group must be age 18 years or older and currently residing in Buckinghamshire (excluding Milton Keynes) and meet each of the following criteria:

1. Have an alcohol and or drug problem

Alcohol Misuse

- Have an enduring pattern of problem drinking for a number of years AND
- Score 20+ on Alcohol use disorders identification test (AUDIT) OR
- Be classified as dependent on Severity of Alcohol Dependency Questionnaire (SADQ) (16-30 = moderate dependence/30 is severe dependence range is 30-60) OR
- Have other markers of dependence on alcohol (Ethanol levels or biomarkers such as Liver Function Test (LFT) scores may also be used)

Drug Misuse

- Have an enduring pattern of problem drug misuse back a number of years AND
- Have had an assessment of their Drug Dependence (Severity of Dependence Scale (SDS) or withdrawal severity using the Clinical Opiate Withdrawal Scale (COWS)

2. Have a pattern of not engaging with or benefiting from drug or alcohol treatment

- Those with problematic alcohol use and/ or drug use would have been subject to Identification and Brief Advice (IBA), or appropriate screening for drug use
- Have been referred to services, usually on more than two occasions, and have not attended, attended, and then disengaged or remained engaged but not changed

3. Impact on public services

Clients will either directly, or via their effect on others e.g., their family, be placing a high impact/high demand on at least one of the following services:

- Health (primary care, secondary care or the ambulance trust)
- Social care including adults involved with children's services
- Criminal Justice / ASB / Domestic violence Services
- Emergency services (999)
- Housing and homelessness agencies
- The burden will be mainly due to:
- Multiple use of multiple or individual services
- Placing an exceptional burden/demand on services because of a single risk (e.g., a sex offender released from prison with a pattern of problematic drinking)

Exception 1 – level of risk

An exception category will be required. E.g., a person may meet the first 2 criteria (dependence & non-engagement) but burden/demand on public services is due to a single exceptional risk.

Exception 2 – engaged with other multi-agency groups

If a person is already engaged with another multi-agency group (e.g., MARAC or MAPPA) they will not be taken on by Blue Light without a clear decision from the other group. The assumption will usually be that management will remain with the existing group.

In addition, the referring agency must ensure there is a legal framework for sharing information about the identified person. Potential legal frameworks are set out in the Blue Light Project Terms of Reference.

It is recognised that this group can only manage a small number of high burden/demand clients at any one time. Therefore, as a check and control on the process: When a new client is presented to the meeting it will be down to the partner agencies to agree that this is an appropriate and manageable referral at that point in time with advice from the specialist drug and alcohol service provider, One Recovery Bucks (ORB).

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