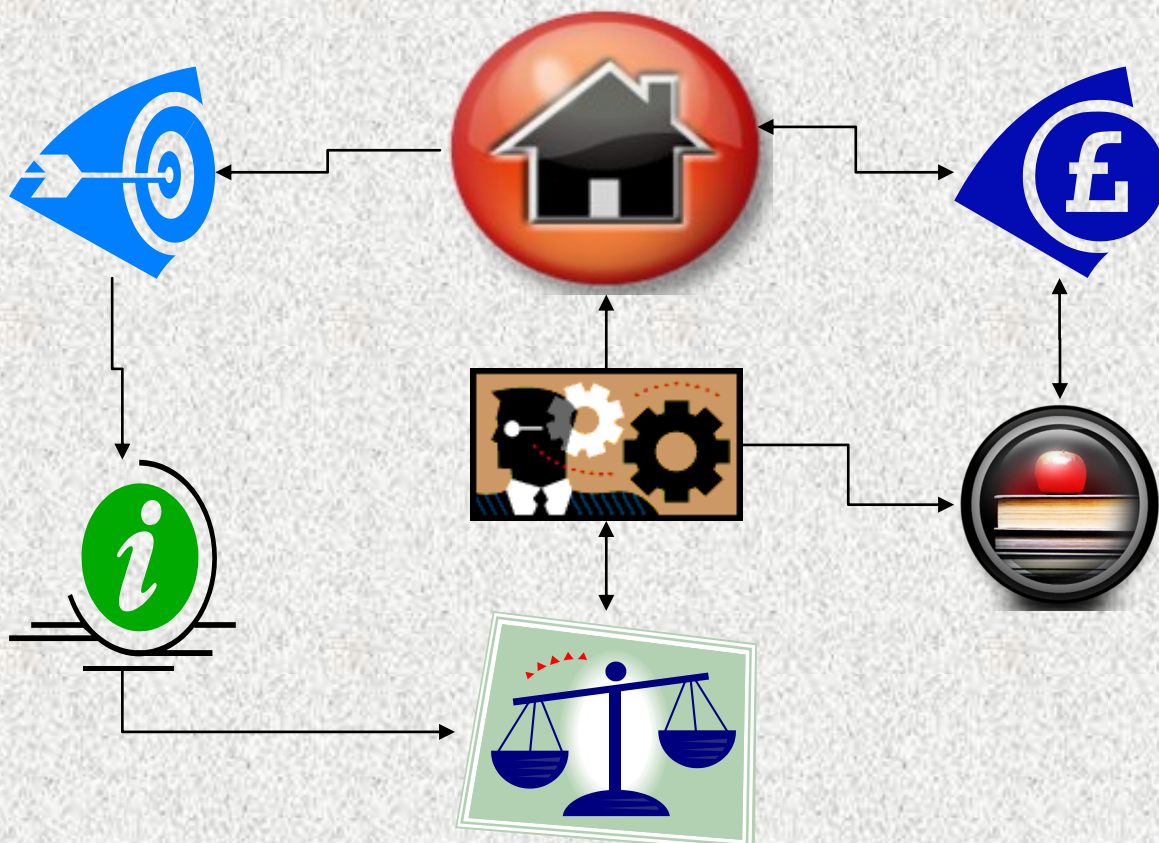


Evaluation and Review
of Tier 4 Alcohol Treatment
Services in the Cumbria and
Lancashire Alcohol Network:
Final Report



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Executive summary

Introduction

The Cumbria and Lancashire Alcohol Network (CLAN) commissioned the Centre for Public Health (CPH) at Liverpool John Moores University (LJMU) to review and evaluate current tier 4 alcohol treatment services, as defined by Models of Care for Alcohol Misusers (NTA, 2006a), in Cumbria and Lancashire. The review determined service provision in the areas within Cumbria and Lancashire using local and national evidence, including the National Drug Treatment Monitoring System (NDTMS). NDTMS data were supplemented with service pro-formas which recorded specific information and served to independently audit activity reported to the National Treatment Agency (NTA). Qualitative information supplemented obtained and derived quantitative information and all data were evaluated in terms of treatment quality, cost effectiveness and commissioning policy.

Tier 4 alcohol treatment services are broadly NHS or non NHS led and function to withdraw alcohol use and stabilise abstinence. As defined by Models of Care, tier 4 is comprised of inpatient detoxification (IPD) and residential rehabilitation (RR), although aftercare (AC) is closely associated with tier 4 service provisions. Historically these provisions were included under the umbrella of the National Mental Health Definition Set and therefore specialist commissioning, which is controlled by regional frameworks. However, their exclusion from the National Mental Health Definition Set will create a change in commissioning responsibility, namely a handover from specialist teams back to PCTs and D(A)ATs. The commencement of the handover has been proposed for April 2010.

MoCAM highlights that the main groups of alcohol users who may benefit from specialist alcohol treatment are those who are moderately and severely dependent. A large proportion of severely dependent drinkers may be in need of inpatient detoxification or residential rehabilitation, although those with specific needs, such as physical or mental health conditions, may benefit from specialist tier 4 care. Such specialism may include facilities or staff expertise in response to specific client need.

A study by the National Treatment Agency for Substance Misuse (NTA) (2005) demonstrated that UK service users perceive that IPD (46%) and RR (58%) would help them achieve their goals; however 64% and 52% reported difficulties in accessing IPD and RR respectively. It was suggested by the NTA (2008b) that since the launch of the first National Drug Strategy in 1998, tier 4 service provision has not uniformly benefited from the improvement in capacity and quality experienced by community-based treatments, however in some areas, the lack of effective tier 4 commissioning processes and structures has resulted in impeded growth and a failure to guarantee funding.

Aims

The primary aim of this research is to inform the future development, commissioning and provision of tier 4 alcohol services in Cumbria and Lancashire by:

- Providing a robust review and evaluation of characteristics, structure and engagement of current tier 4 alcohol services.
- Estimating current and future need for tier 4 alcohol services.
- Evaluating commissioning of tier 4 alcohol services and highlighting areas of good practice.

Methodology

Relevant tier 4 alcohol treatment data were extracted and analysed from the National Drug Treatment Monitoring System (NDTMS). Such information included; client demographics, including sex, age, ethnicity; treatment engagement; secondary and tertiary substance use; referral sources; and treatment outcomes.

To supplement NDTMS information, a pro-forma questionnaire was sent to tier 4 alcohol treatment services in Cumbria and Lancashire. Information collected and analysed via the pro-forma included; service description; setting and accessibility; service capacity; screening and assessment methods; admission and care planning; eligibility criteria; preparation of service users; and treatment interventions, including method, duration and frequency.

Pro-forma questionnaires were supplemented by semi-structured interviews with service managers, the discussion topics of which included; commissioning processes; methods of review and adaptation of programmes; client characteristics and inappropriate referrals; referral sources and onward referral agencies; perceptions of barriers to treatment engagement; data monitoring; utilisation of the evidence base; exit strategies, including policies for unplanned discharge; and community based treatments and aftercare.

To gain the perspective of service users, semi-structured interviews were conducted with clients within recruited services. Discussion topics included; the nature of clients alcohol use; the individual complexities of alcohol related problems; good practice within services; barriers to treatment success; and peer support and aftercare.

To appraise and evaluate commissioning processes and policies, semi structured interviews were conducted with commissioners of tier 4 alcohol treatment services from Specialist Commissioning Teams, PCTs and D(A)ATs from discrete and disparate areas within Cumbria and Lancashire (Blackpool, Cumbria, North Lancashire and Blackburn with Darwen). Discussion topics included; commissioning responsibility; contracting; service specialism; appraising performance; national policy; data monitoring; and service user feedback and personalisation of tier 4.

NDTMS Results

There were 636 individuals in contact with tier 4 alcohol treatment services during 2008/09, of these 617 individuals entered a tier 4 modality of treatment, the remainder were triaged but did not engage with the intervention. Of the 617 individuals, 443 accessed inpatient detoxification interventions, 155 accessed residential rehabilitation interventions and 19 accessed both inpatient detoxification and residential rehabilitation interventions during 2008/09. The 617 individuals accessing tier 4 interventions in Cumbria and Lancashire accounted for 42.1% of those in tier 4 alcohol treatment in the North West of England during 2008/09.

The majority of tier 4 alcohol clients were male (n=411, 66.6%), a proportion similar to all those in contact with tier 4 alcohol agencies throughout the region (n=981, 66.9%). The proportion of females in contact with tier 4 alcohol treatment varied depending on the type of intervention entered. A higher proportion of females entered residential rehabilitation compared to inpatient detoxification during 2008/09, a trend reflected in the comparison of estimated need for increased provision of inpatient detoxification and residential rehabilitation in England (Wilkinson & Mistral, 2007).

The mean age of the total tier 4 population was 42.1 years; over half of the individuals were aged 40 years and older (n=362, 58.7%). The mean age of those in contact with tier 4 agencies was similar when compared to those in contact with tier 4 alcohol treatment throughout the region.

The majority of clients did not state a secondary problematic substance (n=471, 76.3%); of those that did, 66 (45.2%) stated the use of cannabis. Only 7.9% of clients stated a tertiary problematic substance.

The vast majority of individuals stated their ethnicity as White (n=605, 98.1%), which is disproportionate when compared to the White treatment population in the North West (95.6%), and England (88.0%) (Hurst, Marr, McVeigh & Bellis, 2008; NTA 2008a).

NDTMS data indicated 21.9% of clients do not complete tier 4 interventions, which is a substantial proportion and may have the potential to undermine the cost effectiveness and efficiency of tier 4 treatments.

Service Pro-Forma Results

All services recruited returned the service pro-forma questionnaire; of the 10 services, two were NHS led services and eight were non NHS led services.

Three were specialist alcohol units and seven were alcohol and drug units. The average split of engaged clients, of the drug and alcohol units (n=7) was 57.6% alcohol and 42.4% drugs; the percentage of primary alcohol clients ranged between 40.0%-85.0%.

The average fees charged per client per week across non NHS led services (n=8), was £477.50; the fees charged ranged from £406.43 to £623.00 (direct comparisons were not possible between non NHS led services and NHS led services).

In terms of ethnicity, after White, which accounts the vast majority of clients accessing tier 4, the most commonly stated ethnicities were White & Black Caribbean and Not Stated.

Variation between services in terms staffing was observed; substantially higher percentages of clinical staff, of total staff, were reported from NHS led services than non NHS led services.

Services indicated 22.8% of client referrals do not attend, which indicates improvements may be made in referral criteria and processes. Services reported the most common referral sources were Community Alcohol Teams and Social Services.

Service Manager Interview Results

Service manager interviews involved representatives of four services and comprised a mixture of NHS led and non NHS led services. The most notable difference found between participating service managers was the estimated operating capacities; while NHS led services described an inability to meet need and long waiting lists, non NHS led services described consistently operating under client capacity; in some cases services were described as operating at 60% occupancy on average.

Service managers generally agreed that commissioning processes were convoluted; interviewees expressed that different areas operated with varied practice and as PCTs had been redefined over the years, referral responsibility and service catchment areas were not always clear. It was also suggested that needs have not been accurately assessed in some areas, specifically in Cumbria.

Service managers generally drew a distinction between medical management and medical supervision and, while some suggested that NHS led services were more likely to be medically managed, some non NHS led service managers also indicated that their services were medically managed. The implication of utilising 24 hour medical management was that such services were better equipped to accept patients with more severe or complex physical and mental health conditions. Service managers generally agreed that not every service would necessarily be capable of accepting a broad spectrum of clients depending on facilities, capacity, staff specialism and level of medical management.

Service managers suggested that data monitoring was fundamental in ascertaining treatment effectiveness. However, some interviewees expressed relatively less enthusiasm and belief in data monitoring processes, expressing that the feedback of information and reporting was seldom used constructively. Service managers agreed that consistent monitoring templates would be welcomed by services and commissioners and would aid accurate and timely reporting of such information.

Service managers expressed shared commitment to improving treatment pathways by developing and utilising a robust evidence base. It was suggested that aspects of tier 4 treatment interventions,

such as inpatient detoxification, have been under the scrutiny of clinical research and have been refined in keeping with up to date information, however, interviewees generally expressed that psycho-social interventions have been less robustly researched.

Service managers discussed the possibility of reducing the burden on tier 4 services by either treating a proportion of presenting individuals in a community setting or by modularising aspects of tier 4 services so that clients only take provisions for what care managers and service managers recommend. Interviewees concurred that, in most cases, community based treatments were inappropriate for dependent alcohol users since detoxification is abstinence based; it was suggested that reaching abstinence within a community setting was more difficult than in a tier 4 setting. Interviewees agreed that modularising and personalising tier 4 treatment would improve outcomes but that modernisation and integration of tier 4 was a prerequisite to such facilities.

Service User Interview Results

Service users discussed the personal consequences of dependent drinking, expressing that alcohol affects individuals in different ways and, when coupled with underlying physical or mental health conditions, often the level of staff attentiveness and the attitude of the patient play a key role in determining treatment success. Interviewees described the importance of having a mentor to guide them and instil belief within the client that abstinence could be achieved.

Service users described a points scoring system upon presentation to services, preceding tier 4 treatment, which operates to determine the level of dependence to alcohol. Interviewees described inaccuracies with this system, the main criticism being that dependent drinkers, ideally suited to tier 4 interventions, may not score the required points and not receive an appropriate referral in some instances. Interviewees generally described tier 4 alcohol treatment to be a 'completely essential' service; it was further suggested that community based detoxifications were generally insufficient for dependent drinkers.

Service users agreed that waiting times were a major barrier to treatment success; it was described that excessive waiting times existed in some areas and that individuals, having been put on a long waiting list, may be drinking at home or on the street within the same day. Interviewees described how varied systems were in place in different local authorities and the lack of consistency had led some treatment seekers to take themselves out of area in order to receive quicker interventions.

Service users commonly agreed that the educational elements to tier 4 were extremely important in helping service users, their family and friends, to understand the root causes of an individual's drinking behaviour. It was expressed that detoxifications in hospital settings often lacked an educative element when compared to specialist units. Interviewees also agreed that more preventative measures and information could be available for young people and those mechanisms ought to operate as strategic community outreach.

Service users described that upon discharge the individual 'has a choice again' and is left with 'a psychological challenge'. Interviewees described how contact ought to be extended from tier 4

services, including the incorporation of wrap-around support facilities, to help combat the psychological barriers to maintaining abstinence. Service users also described aftercare and support services as crucial aspects of the treatment journey and emphasised the importance of group meetings and peer support.

Commissioner Interview Results

Commissioners ultimately suggested that variation in policy and process underpins inconsistencies and barriers to tier 4 alcohol commissioning and service provision in these areas. Commissioners from certain areas described how tier 4 alcohol commissioning was the responsibility of specialist commissioning teams, while others described how commissioning in their areas was the responsibility of both D(A)AT and PCT representatives. It was highlighted that in areas overseen by specialist commissioning that, at the time of interviews, the responsibility was in the process of changing hands from specialist commissioners back to the PCTs and D(A)ATs. Interviewees described how such a shift, would have a multitude of consequences and interviewees expressed wide ranging opinions regarding this change.

Commissioners from specialist commissioning areas agreed that, while current responsibility was with specialist commissioning teams, PCTs and D(A)ATs had an unsatisfactory level of communication or involvement with the commissioning process. Representatives of local D(A)ATs expressed that the main benefit to more locally based commissioning was the influence of local knowledge. It was suggested that such specific parameters could reshape commissioning based closely on local need, geography and characteristics. Converse to the opinion of specialist commissioning representatives, such commissioners argued that local D(A)ATs were better positioned to achieve improved value for money. However, interviewees expressed that PCT management of funding would benefit from an overseeing body and commonly agreed the only capable organisation would be the Strategic Health Authority (SHA).

Commissioners in some areas described how budgeting and assignment of funding was managed by multiple positions and bodies; it was suggested for this reason that, on occasions, commissioning lacked direction and leadership and that collective aims should include equity across and between counties. Commissioners commonly expressed that with the initiative of World Class Commissioning, there was an obligation to move away from procurement on the basis of historical relationships.

Commissioners from some areas described advantages of spot purchased contracts rather than block purchasing, suggesting that such contracts enabled greater flexibility and could lead to better outcomes. Interviewees described that, while spot purchased contracts were more labour intensive, they may be ultimately more cost effective, if well managed, since commissioners have more control over the quality of service purchased.

Commissioners emphasised the need for performance based commissioning derived from accurate monitoring information but that performance was not easy to determine in all cases owing to gaps and inconsistent reliability of monitoring data. Interviewees indicated that consistent performance indicators would be ideal in commissioning tier 4 alcohol interventions but that such consistency was

difficult to achieve since service providers varied in terms of clinical expertise, working practices models, treatment journey planning, therapeutic community emphasis, personalisation, user choice and integration with other tiers.

Commissioners suggested that integrated modelling of tier 4 would be of substantial benefit, from which tiers 2 and 3 could provide a useful framework. Interviewees also suggested that alcohol was considerably behind drugs in terms of a nationally defined service practice models.

Commissioners commonly agreed that service user feedback was extremely important and that tier 4 service commissioning would benefit from the development of service user forums. Interviewees from some areas described how service user feedback was instrumental to the development of integrated care pathways.

Commissioners widely acknowledged that tier 4 services were becoming more personalised in line with widespread recognition that tailoring services to the individual may substantially improve treatment outcomes. It was suggested that not all aspects of tier 4 treatment were relevant for all services users and that breaking aspects of the intervention down would streamline treatment, enabling clients to engage in modules most relevant to them.

Commissioners across areas concurred that rigorous needs assessments were not always carried out and would be very likely to improve the efficiency of tier 4 alcohol service commissioning. It was suggested that service provision was not closely correlated to accurate needs assessments but that without modernisation and integration of tier 4 alcohol interventions accurate needs assessments were difficult to execute.

Conclusions

Commissioners suggested that this review may provide timely insight into good practices and barriers to successful commissioning of tier 4 alcohol services, especially in light of the current economic climate, which has led to many PCTs attempting to streamline costs where possible.

While specialist commissioning representatives expressed concern that the priority of tier 4 alcohol treatment may not be maintained by all PCTs, service managers suggested that the proposed removal of the specialist commissioning component was generally met with approval and that, rather than gain benefits from commissioning specialists, the change would 'remove a middle layer' and potentially improve the accuracy of commissioning based on local need. Commissioners emphasised that transitional periods must be carefully planned in order not to risk the destabilisation and closure of services in the short and intermediate term.

It was generally expressed that improvements in link-up and collaboration are required between:

- PCTs, D(A)ATs and specialist commissioners.
- Commissioners and service providers.
- Services and service users.
- Service users and commissioners.

Commissioners expressed that PCT management of funding would benefit from an overseeing body, namely the SHA; further suggesting that without coordination and 'linked-up' commissioning, accurate appraisals of need and the relative weighting of alcohol and drug services were very difficult to determine.

To date there have not been rigorous or consistent needs assessments carried out in each PCT area within Cumbria and Lancashire. Service managers suggested that for some localities, it may be cheaper to utilise 'out of area' services than local providers. Development and utilisation of the Prevalence to Service Utilisation Ratio may greatly assist this task, assuming such a ratio may be derived from available data.

NDTMS data suggest that engaging service users may be disproportionate of dependent drinking populations and that better outreach is required for disengaged groups. For example, representatives of Black and Minority Ethnic populations may experience substantial barriers to alcohol treatment, especially tier 4 interventions.

Service managers agreed that treatment providers should be commissioned primarily on performance, however some interviewees expressed that performance was not always easy to determine since services demonstrate a varied level of prioritisation relating to NDTMS reporting. Commissioners concurred that data monitoring was the only genuine mechanism to ascertain service performance but that there were shortfalls in standard monitoring mechanisms, such as gaps and inaccuracies in the data.

NHS led service managers described considerable shortfalls in tier 4 service provision and excessive waiting lists, while non NHS led service managers described operating under capacity in terms of occupancy, in some cases by as much as 40%. Commissioners and service managers expressed that in depth needs assessments married up to accurate monitoring information across areas may facilitate overarching analyses and a drive towards collaborative referring. Utilisation of innovative techniques, such as Dynamics Modelling, may aid the achievement of this target.

The proportions of clinical staff of total staff and the level of medical management vary between services. Whether such differences vary by service constitution or provider, clients ought to be referred on a case by case basis and appropriately matched according to the complexity and nature of their need.

Service users identified loneliness and worthlessness as the overriding feelings of dependent drinkers and also described feeling stigmatised by the general public, even after moving to stable abstinence. Service users suggested that alcohol affects people individually, especially when coupled with poly-drug use and physical or mental health conditions.

Service users described tier 4 treatment interventions to be 'completely essential' and without alternative, declaring that their 'mind set' was never the same after their first inpatient detoxification. It was suggested that, in most cases, community based treatments were inappropriate for dependent alcohol users. Service users indicated a strong influence and key

determinant of treatment success was the state of mind, outlook and attitude of the individual but that the ability of a care manager or key worker to mentor and inspire was also extremely important.

Commissioners expressed that changing the perceptions and culture of policy makers and stakeholders regarding tier 4 alcohol interventions is a key aspect of maintaining the long term funding and prioritisation of such treatment.

Recommendations

- Assess the feasibility of conducting in-depth needs assessments by area, including analysis of client occupancy levels. To assist in this task, explore the potential to derive Prevalence to Service Utilisation Ratios (PSURs), including appraisals of the accuracy of required data.
- Where possible, ensure the utilisation of consistent and robust monitoring processes throughout services of all constitution types and across areas. Work with service providers to ensure all services routinely submit accurate data to the NDTMS.
- Consider investment in the development and utilisation of robust performance indicators; support World Class Commissioning by commissioning based on performance wherever possible.
- Appraise the potential to create a referral template, which may be applied to a given area and that aids in the selection of service provision according to the level of client complexity or condition. Where there are shortfalls in service information, appraise services for clinical expertise and refer to specialists based on specialist need. Consider the potential to implement and utilise such a template across referral sources to improve referral pathways and reduce the proportion of non-attending clients.
- Assuming specialist commissioning is disbanded (as proposed) attempt to maintain a collaborative approach to commissioning across PCT areas and ensure the handover and transitional period is carefully managed and overseen to avoid service destabilisation. Encourage the involvement of the SHA to oversee localised PCT and D(A)AT commissioning.
- Analyse the potential to reduce incentives for PCTs not to under-spend; consider the feasibility of allowing PCTs to re-invest a proportion of saved funding.
- Where data are available, utilise overarching monitoring information to assess the feasibility of balancing low occupancy levels in some services or areas with excessive waiting lists in other services or areas.
- Consider investment in the modernising and integrating tier 4 alcohol interventions with the other tiers of alcohol and drug treatment; where possible develop and enhance links with the lower tiers of treatment, community-based services, aftercare and wrap-around services.
- If agreed and deemed appropriate by the individual, their care manager and involved services, consider the potential to utilise community-based detoxifications for dependent drinkers with relatively less complex needs.
- Consider focus and investment in the ongoing development and improvement of a shared, cross-area, evidence-based manual for inpatient detoxification programmes and psycho-social interventions.

- Consider the potential to implement modularisation and individualisation of tier 4 alcohol services with a view to improving the cost effectiveness of interventions and tailoring treatment to the individual. Assess the effect of modularisation and individualisation on treatment efficacy and assess the feasibility of their incorporation into mainstream tier 4 alcohol services.
- Where possible, consider trialling innovative mechanisms, such as 'Virtual Wards', and evaluate the ability of such mechanisms to reduce currently observed inefficiencies in referral and treatment engagement processes.
- Consider the utilisation of system models, such as 'Dynamic Modelling', to provide an overview of gaps in service provision, to map treatment journeys and to record the movement of individuals between tiers of treatment and the community.
- Appraise staff moral and counsellor case load as key determinants of treatment success.
- Develop, support and encourage 'in & out' patient groups as part of peer-led support, especially in the context of improving the transition from tier 4 services back to the community.
- Consider the potential to develop educational elements of tier 4 alcohol treatment, including the incorporation of family and friends in this process, where possible.
- Encourage the development of strategic educational and preventative mechanisms in the community, especially for young people.
- Consider the feasibility of appraising, developing and utilising non NHS-led services, where satisfactory performance can be demonstrated. Assess the potential to utilise such services for appropriate clients to reduce waiting times and out of area referrals.
- Consider the potential to offer block purchased contracts for services where consistent performance can be demonstrated.
- Consider the potential to offer trial spot purchased contracts for relatively newer services, where performance has yet to be robustly demonstrated.
- Continue the investment and development of independent service user forums and, where possible, utilise derived information to improve and integrate specific aspects or processes of tier 4 alcohol interventions.
- Consider appraising and addressing the cultural beliefs and stigmas surrounding alcohol dependency and tier 4 alcohol treatments among relevant stakeholders and the wider public.

1.0 Introduction

The Cumbria and Lancashire Alcohol Network (CLAN) commissioned the Centre for Public Health (CPH) at Liverpool John Moores University (LJMU) to review and evaluate current tier 4 alcohol treatment services, as defined by Models of Care for Alcohol Misusers (NTA, 2006a), in Cumbria and Lancashire. The review will determine service provision in the areas within the CLAN footprint using local and national evidence, including the National Drug Treatment Monitoring System (NDTMS). NDTMS data were supplemented with service pro-formas, which recorded specific information and served to independently audit activity reported to the National Treatment Agency (NTA). Qualitative information supplemented obtained and derived quantitative information and all data were evaluated in terms of treatment quality, cost effectiveness and commissioning policy.

1.1 Alcohol Use & Treatment

The updated National Alcohol Strategy (Safe. Sensible. Social) aims to reduce the harms caused by alcohol by emphasising the promotion of sensible drinking. The government recommends that men should not regularly drink more than 3-4 units of alcohol per day and women should not regularly drink more than 2-3 units of alcohol per day (1 unit = 8g or 10ml alcohol). The Alcohol Needs Assessment Research Project (ANARP, 2004), commissioned by the Department of Health, found that 32% of men and 15% of women in England (age 16–64) drink at hazardous or harmful levels (23% overall), equating to approximately 7.1 million people. Furthermore, 6% of men and 2% of women in England (approximately 1.1 million people) are dependent drinkers, although variations in overall prevalence between areas range from 1.6% to 5.2% (ANARP, 2004).

Alcohol misuse is associated with a wide range of problems, including physical health conditions, such as cancer and heart disease; offending behavior, not least domestic violence; suicide and deliberate self harm; child neglect; mental health problems, which co-exist with alcohol misuse; and social problems such as homelessness (*Model of care for alcohol misusers*, MoCAM, 2006a). It has been demonstrated that there is a direct dose-response relationship between alcohol consumption and risk of death (White et al., 2002). Since evidence indicates that problematic drinking and the associated harms can be preventable, one of the main aims of the *Alcohol Harm Reduction Strategy for England (2004)* is 'to better identify and treat alcohol misuse'.

The introduction and development of comprehensive, integrated, local alcohol treatment systems considerably benefits hazardous, harmful and dependent drinkers, their families, social networks and wider communities (MoCAM, 2006a). In addition to the individual and social benefits, alcohol treatment has also been shown to have short and long term benefits to the economy. The United Kingdom Alcohol Treatment Trial (UKATT) found, when considering social behaviour and network therapy and motivational enhancement therapy, that each treatment saved about five times as much in expenditure on health, social, and criminal justice services as they cost (2005). MoCAM suggests that commissioners should ensure that a range of services for alcohol misusers are available and that services should form a local alcohol treatment system designed to meet local needs. In *Models of Care* (2006a), the NTA groups alcohol and drug treatment into four tiers, which reflect increasing intensities of intervention. Tier 4 interventions include provision of residential,

specialised alcohol treatments which are care-planned and coordinated to ensure continuity of care and appropriate aftercare. The settings for tier 4 alcohol treatment are broadly NHS or non NHS led and function to withdraw alcohol use and stabilise abstinence. As defined by Models of Care, tier 4 is comprised of inpatient detoxification (IPD) and residential rehabilitation (RR), although aftercare (AC) is closely associated with tier 4 service provision. Tier 4 services settings are also useful for further assessment of those with complex needs. Making effective use of tier 4 treatment programs, according to MoCAM (2006a), also requires; that clients are comprehensively assessed; that client choice is respected; that care is planned and reviewed; that alcohol use is stabilised or clients have been detoxified; that aftercare is integral to the treatment process; that housing needs are met; that education, training and employment needs are supported; that social and life skills are developed; and that departure is planned.

Tier 4 treatment interventions usually involve episodes of hospital-based or equivalent alcohol medical treatment, sometimes including 24-hour medical cover and multidisciplinary team support for treatment interventions, which include; comprehensive assessment of complex cases; care planning; prescribing interventions for medically assisted alcohol withdrawal; prescribing interventions to reduce the risk of relapse; evidence-based psychosocial therapies and support to address alcohol misuse (NTA, 2009). The main settings for tier 4 alcohol treatment typically include; dedicated specialised inpatient alcohol detoxification units; residential rehabilitation units for alcohol misuse; specialised facilities; and general psychiatric wards for patients with co-morbid mental illness. Tier 4 alcohol treatments consists of a range of delivery models to address alcohol misuse, including medically assisted alcohol withdrawal, prescribing for relapse prevention and abstinence-oriented interventions within the context of residential accommodation (NTA, 2009).

Inpatient detoxification is a form of acute care for the purpose of completing a medically safe withdrawal and is typically indicated when there is a risk of severe withdrawal symptoms that cannot be safely managed in a less intensive detoxification setting (UBH, 2009). Residential rehabilitation provides care planned programmes of therapeutic and other activities suitable for patients with medium to high dependence on alcohol. Residential rehabilitation programmes can be generally divided into long stay, short stay, intensive, lower intensity and support (NTA, 2006b). Tier 4 services are required to comply with a wide range of standards according to the provided services and their registration status, in line with Drug and Alcohol National Occupational Standards (DANOS). Registered care home are also expected to meet national minimum standards and are inspected by the Commission for Social Care Inspection (CSCI).

1.2 Service Users

MoCAM highlights that the main groups of alcohol users who may benefit from specialist alcohol treatment are those who are moderately and severely dependent. A large proportion of severely dependent drinkers may be in need of inpatient assisted alcohol withdrawal and residential rehabilitation, although those with specific needs, such as physical or mental health problems, may benefit from specialist inpatient units, which may entail specialist facilities or staff expertise in response to specific client need. Approximately one third of alcohol dependent individuals referred to treatment actually access treatment (ANARP, 2004), suggesting that there is considerable

potential to increase engagement with services. Of referrals to specialist alcohol services, 36% were self referred (ANARP, 2004), which highlights the need to initiate improved access to treatment, including better publically available information, and identify and analyse the capacity of specialist treatment services. Currently, tier 4 provision is insufficient to meet demand and this under-provision will intensify if public sector treatment target numbers are met without increasing tier 4 capacities (NTA, 2005). However, owing to wide regional variation and discrepancies among the data, any review of tier 4 treatment service availability and quality must be area specific and interpreted in relation to the national context.

Evidence based on user feedback highlights weaknesses in aspects of client preparation, assessment, throughcare and aftercare, in addition to a perceived inflexibility in matching provisions to individual need (NTA, 2005). While treatment programmes are becoming more holistic in nature, there is undoubtedly disproportional representation of specific groups accessing treatment. Such under representation of certain groups, including pregnant women, women with children, young people and individuals from Black and Minority Ethnic (BME) groups (NTA, 2005), requires redress in service engagement and communication with these groups. Analysis of the gap between need and service provision can be estimated by analysing the Prevalence to Service Utilisation Ratio (PSUR) (ANARP, 2007); such data would include estimates of dependent drinker prevalence and numbers accessing tier 4 alcohol treatment.

Research indicates that, of 80 Drug and Alcohol Action Team (D(A)AT) professionals, 19% identified BME groups, 16% identified rural communities, 14% identified women, 11% identified homeless people and 10% identified asylum seekers or refugees as disadvantaged or underrepresented in tier 4 treatment (ANARP, 2004). Since 25% of dependent drinkers are women (ANARP, 2004), representation in treatment ought to equate to a similar proportion, however evidence suggests that women are underrepresented (Simpson & McNulty, 2009). Similarly, while BME groups have a considerably lower prevalence of hazardous or harmful alcohol use, such groups on average have a similar prevalence of alcohol dependence compared with the white population (ANARP, 2004), therefore the proportion accessing specialised tier 4 services ought to equate to the proportion of the population of those groups in a given area.

1.3 Local Alcohol Profiles for England

Local Alcohol Profiles for England (LAPE) is an online tool, created and updated annually by the North West Public Health Observatory (NWPHO), and provides data by area on alcohol related health and criminal justice system indicators. Such data include hazardous, harmful and binge drinking estimates, alcohol related hospital admissions, mortality and alcohol related crime estimates (Hannon, Morleo & Cook, 2008). Table 1 demonstrates key information for PCT areas in Cumbria and Lancashire.

Table 1 – Key Alcohol Related Estimates for CLAN Areas by PCT

(* = above, ** = significantly above, - = below, -- = significantly below the national average)

	Cumbria	Central Lancs	East Lancs	North Lancs	Blackburn & Darwen	Blackpool
Alcohol-specific mortality - males	--	**	**	-	**	**
Alcohol-specific mortality – females	-	*	*	**	*	**
Mortality from chronic liver disease – males	--	**	**	**	**	**
Mortality from chronic liver disease - females			*	**	*	**
Alcohol-attributable mortality – males	-	*	*		*	**
Alcohol-attributable mortality – females	*		*		*	**
Alcohol-specific hospital admission – under 18s	**	**	**	*	**	**
Alcohol-specific hospital admission - males	**	**	**		**	**
Alcohol-specific hospital admission -females	**	**	**	**	**	**
Alcohol-attributable hospital admission - males	**	**	**	--	**	**
Alcohol-attributable hospital admission – females	**	**	**		**	**
Hospital admissions for alcohol-related harm	**	**	**	--	**	**
Alcohol-related recorded crimes	--	--	--	--	*	**
Alcohol-related violent crimes	--	--	--	--	**	**
Alcohol-related sexual offences	--	-	*	-	*	**
Claimants of incapacity benefits - working age		**	**	**	**	**
16						
Mortality from land transport accidents	**		-	-	-	--
Hazardous drinking (synthetic estimate)	-		-		-	-
Harmful drinking (synthetic estimate)	-		-	-	*	*
Binge drinking (synthetic estimate)	**	**	**	**	*	**
Employees in bars	**	**	**	**	--	**

(LAPE, 2005)

1.4 Needs Assessments

The Alcohol Needs Assessment Research Project (ANARP), commissioned by the Department of Health, presents data at a national and regional level to highlight the range of alcohol use disorders in the population and the range of relevant alcohol treatment services currently available. ANARP suggest a gap exists between the need for alcohol treatment and access to treatment services, with estimates of one in 18 (5.6%) alcohol dependent individuals accessing specialist treatment per annum (2004). The PSUR varies between areas and can be a useful tool in determining regional gaps in service provision.

According to the NTA only 34% of commissioners who participated in a research study, had carried out local needs assessments (despite this activity being an integral part of the D(A)AT treatment planning process) and only 52% of residential services had taken part in any research, evaluation or audit within the last five years. Such shortfalls in data collection and therefore the evidence base, inhibit the identification of user need and the monitoring of services, which contribute to the inhibition of improvements and developments of tier 4 alcohol services. The fundamental aims of the Alcohol Health Needs Assessment (AHNA) are to describe the nature, scale and consequences of misuse; describe the existing services in relation to MoCAM and evidence based practise; to obtain stakeholder views regarding gaps and priorities for service development; and make recommendations to the local alcohol strategy group (NHS, 2008).

1.5 Inpatient Detox (IPD) & Residential Rehabilitation (RR)

A study of UK service users by the NTA (2005) demonstrated that 46% and 58% of participants perceived that IPD and RR respectively, would help them achieve their goals, however, 64% and 52% of participants reported difficulties in accessing IPD and RR respectively. A survey of 64 RR UK alcohol and drugs services found an average of 58 admissions per service annually for 2003/4, with occupancy rates ranging from 40-98%, but failure to differentiate between drugs and alcohol service, places severe limitations on the data (NTA, 2005). These limitations are emphasised by the discrepancy between calculated estimates and NDTMS reported figures. A survey of 92 IPD units found an average of 117 admissions per service annually for 2003/4 but the work highlighted variations in scope, physical location, staffing and clinical practice and an overall absence of minimum standards and consistency of provisions, even among the specialist providers of IPD service (NTA, 2005). A survey of 67 joint commissioning managers revealed the mean waiting time for RR, consistent with NDTMS reporting, was just over two weeks, 59% of referrals arrived via community treatment and the overall completion rate was 34% (NTA, 2005). For IPD, the mean waiting time was approximately four weeks; referral rates were very similar to that of RR, as was the overall completion rate of 34% with most referrals coming via tier 3 services (NTA, 2005). Joint commissioning managers perceived the need for an additional 33 places for RR and 76 additional places for IPD, on average per D(A)AT (NTA, 2005).

In terms of effectiveness, residential rehabilitation for drug misusers demonstrates improved outcomes in a series of research studies (Bennett & Rigby, 1990; Gossop *et al*, 1999); suggesting that better outcomes are demonstrated for clients with more severe problems for stays of 90 days or longer (Simpson, 1997). However, it has been suggested that assessing tier 4 effectiveness is limited by relatively high drop-out rates. Evidence also indicates that individuals who receive treatment in dedicated units are more likely to demonstrate better outcomes than those who receive treatment in general psychiatric wards (NTA, 2009). Tier 4 alcohol treatment effectiveness is also linked with longer stays, increased number of beds, increased single room facilities, decreased waiting times and the presence of facilities for specialist groups, such as pregnant women (NTA, 2006b).

1.6 Data Monitoring

Originally developed to collect data on adult drug misusers in contact with structured drug treatment, the NDTMS now supports data from providers of both specialist drug and alcohol treatment. Data is reported to the public, commissioners and local, regional and national government. The NDTMS system captures information on individuals presenting to specialist services and follows their treatment journey and outcomes, incorporating Treatment Outcome Profiles (TOPs) data. Information is collected, validated and analysed to monitor treatment service outcomes and performance, which relate to key objectives outlined by the NTA. In April 2008, the Department of Health recommended the NTA implement data collection on all clients receiving specialist treatment for their problematic alcohol use, the NDTMS was expanded to collect data on all individuals accessing specialist alcohol treatment at both drug and alcohol, and alcohol specific services. The alcohol subset of the NDTMS records information via a clinical information system or a web based data entry tool and includes demographic information on the client referral source into treatment, type of treatment intervention entered and reason for exit at treatment discharge.

In the context of this review and evaluation, NDTMS data will guide research based on historical evidence, help determine uptake and capacity in service provision and assist in identifying gaps and breakdowns in service reporting of monitoring information. It is by developing and improving monitoring of services that effectiveness can be determined and compared between services and local areas. Progress towards effectiveness is best highlighted and achieved when short and long term objectives are clear, indicators are reliable and reflect real changes and consistency is achieved in level and accuracy of reporting. Commissioning based on performance, as determined by regular assessment of need, accurate reporting of monitoring information and the derived evidence base, is essential to improving the efficiency and cost effectiveness of tier 4 alcohol treatment.

1.7 Commissioning & Good Practice

It was suggested by the NTA (2008b) that, since the launch of the first National Drug Strategy in 1998, tier 4 service provision has not uniformly benefited from improvements in capacity and quality, however in some areas, the lack of effective tier 4 commissioning processes and structures has resulted in impeded growth and a failure to guarantee income streams. The improvement in tier 4 provision is a priority of the NTA's Treatment Effectiveness Strategy (2005) and, while dependent on D(A)ATs and PCTs to carry out joint strategic needs assessments of their populations, the NTA have identified guidelines for improved commissioning policy. Integral to the guidelines are the following principles; commissioning of tier 4 service provision should be evidenced based, including ongoing assessment and review against performance targets; users are put at the heart of the tier 4 commissioning process, both at the individual and collective level; commissioners of different types of tier 4 service work in close collaboration under the consistent strategic umbrella of the Local Drug Strategy; and local partnerships should review arrangements to ensure commissioning is carried out in the most efficient way (NTA, 2008b). Local commissioning practice can be improved by application of commissioning guidelines, while understanding and accounting the dynamics and characteristics of a given area.

The challenges that exist in the commissioning process require attention and consideration if efficiency is to be improved. The NTA (2008b) identifies the following broad challenges and barriers; a lack of coordination and communication between joint commissioning groups at a strategic level; varying criteria for accessing services between areas, (for example, robust and clear policies exist in some areas but not others); historically some providers have been poor at returning NDTMS data, making monitoring of activity more difficult; integrated care pathways are sometimes poorly defined or adhered to; commissioning is anecdotally thought to be administered based on history as opposed to effectiveness; some commissioners and services have been slow to develop according to what users and carers outline; and some providers reported the need to chase up invoices or invoicing being conducted retrospectively. Commissioning processes in the CLAN areas were examined in terms of these challenges with findings helping to shape appropriate recommendations and refine local commissioning policy.

In response to these challenges, the NTA (2008b) identified areas of good commissioning practice. It is suggested that specialist commissioners and D(A)AT partnerships address the following issues as part of their routine commissioning cycle:

- The need, taken from the NTA's Needs Assessment Guidance (NTA, 2007), to identify the level and type of tier 4 service provision residents are likely to require throughout the financial year, this requires consideration of many factors.
- Involving users and carers in the commissioning process by encouraging active involvement in feedback and strategic planning; consider block contracting in terms of current contracts and stable contracts for the most effective or cost efficient services.
- Consider spot purchasing to maintain flexibility to commission services based on more specific needs.
- Preferred provider models based on cost effectiveness for both block and spot purchasing; registration under the Care Standards Act (2000) or, if an independent residence, the Healthcare Commission.
- Clear and agreed local care pathways, including consistent and appropriate eligibility and suitability criteria, in line with Care Planning Practice Guide (NTA, 2006b).
- Early intervention to inpatient detoxification treatment or residential rehabilitation to prevent more problematic use by younger people.
- Interventions for individuals in the Criminal Justice System, the surrounding issues of which will also be considered in the full report.
- Preparation of clients in terms of creating comprehensive assessments, which have the potential to determine success of tier 4 treatments; inter-partnership care pathways, especially relevant when service providers are not in the same locality as clients' area of residence.
- Treatment duration based on the evidence base; commissioning adequate aftercare to consolidate treatment gains; use of specialist funding panels, comprised of local experts, to make specific decisions about clients' treatment pathways.

This rigorous model of good practice will be considered in detail and relate to local commissioning policy and process in the CLAN areas.

1.8 Aims & Objectives

The primary aim of this research is to inform the future development, commissioning and provision of tier 4 alcohol services in Cumbria and Lancashire by:

- Providing robust review and evaluation of characteristics, structure and uptake of current tier 4 alcohol services.
- Estimating current and future need for tier 4 alcohol services.
- Evaluating the commissioning of tier 4 alcohol services and highlighting areas of good practice.

The objectives and outcomes of the review and evaluation are to:

- Map current service provision and investment in each D(A)AT or equivalent locality and in totality for Cumbria and Lancashire including by population size.
- Review current provision of tier 4 services.
- Review current commissioning of tier 4 services in each D(A)AT or equivalent locality.
- Review of care pathways for individuals requiring tier 4 interventions in each D(A)AT or equivalent locality.
- Highlight existing good commissioning practice across Cumbria and Lancashire.
- Review need in relation to current provision and performance.
- Apply epidemiological planning approach to estimate level and type of need (including quantity and cost) for tier 4 services by D(A)AT or equivalent locality and in totality.
- Recommend level and type of specialist tier 4 alcohol services by D(A)AT or equivalent locality and in totality.
- Recommend a consistent evidence based approach for commissioners of tier 4 alcohol services to implement locally.

2.0 Methodology

The review and evaluation consists of a number of research methods.

- A scoping exercise was undertaken to determine current service provision in each area of Cumbria and Lancashire that provides tier 4 alcohol treatment interventions. This was based on national and regional evidence and incorporated NDTMS information to review and assess activity reported to the NTA.
- NDTMS data were extracted and analysed in order to ascertain information relating to; client demographics, including age, sex, ethnicity and accommodation status by service provider; uptake into treatment by PCT; secondary and tertiary substance use; dual diagnosis; referral sources; access to intervention types; and treatment outcomes. Where information was available, this descriptive dataset was used to highlight past and present service user demographics and profiles. The NDTMS data were also used to review service performance and outcomes.
- A pro-forma questionnaire was designed and distributed to all tier 4 alcohol treatment services in Cumbria and Lancashire. Information collected and analysed included; service description; setting and accessibility; service user capacity; screening and assessment methods, admission and care planning; eligibility criteria; preparation of service users; and treatment interventions, including method, duration and frequency.
- Pro-forma data was supplemented by semi-structured interviews with service managers, which lasted approximately 30 minutes and were conducted by telephone. Flexibility in structure allowed interviews to be guided by issues deemed important by service managers. Discussion topics included; commissioning processes; methods of review and adaptation of programmes; client characteristics and inappropriate referrals; referral sources and onward referral agencies; perceptions of barriers to treatment engagement; data monitoring; utilisation of the evidence base; exit strategies, including policies for unplanned discharge; community based treatments; and aftercare.
- In order to identify and evaluate commissioning processes and policies, semi structured interviews were conducted with commissioners and commissioning partners of tier 4 alcohol treatment services in Cumbria and Lancashire. Interviews lasted approximately 30-45 minutes and took place within an appropriate D(A)AT or Primary Care Trust (PCT) setting. Flexibility in structure allowed interviews to be shaped by issues deemed important by the commissioner. Discussion topics included; how services are commissioned or purchased; financial parameters; engagement of users; and local reporting mechanisms agreed between commissioners and service providers.
- In order to gain the perspective of service users, semi-structured interviews were conducted with clients within services. Discussion topics included; the nature of alcohol use; the individual complexities of related problems; good practice within services; barriers to

treatment success; and peer support and aftercare. Interviews lasted approximately 30 minutes and took place within services and explored specific aspects of treatment journeys and associated experiences. Flexibility in structure allowed interviews to be shaped by issues deemed important by service users.

- Pro-forma questionnaires and existing NDTMS data were also comparatively analysed to audit the accuracy of data monitoring recording and reporting.

2.1 Ethics

This research was ethically approved by Liverpool John Moores University Ethics Committee. Participants were provided with a participant information sheet, which was verbally explained. Participants had the opportunity to ask questions and, if successfully recruited, gave informed written consent.

3.0 Results

3.1 NDTMS Data – CLAN Providers

There were 636 individuals in contact with tier 4 alcohol treatment services in the CLAN areas in 2008/09. Of these, 617 entered a tier 4 modality of treatment, while the remainder were triaged but did not engage with the tier 4 interventions. Of the 617 individuals, 443 accessed inpatient detoxification interventions, 155 accessed residential rehabilitation interventions and 19 accessed both inpatient detoxification and residential rehabilitation interventions (see figure 1). The 617 individuals accessing tier 4 interventions in CLAN agencies accounted for 42.1% of those in tier 4 alcohol treatment in the North West during 2008/09.

Figure 1: Number of individuals accessing inpatient detoxification and/or residential rehabilitation within tier 4 CLAN services

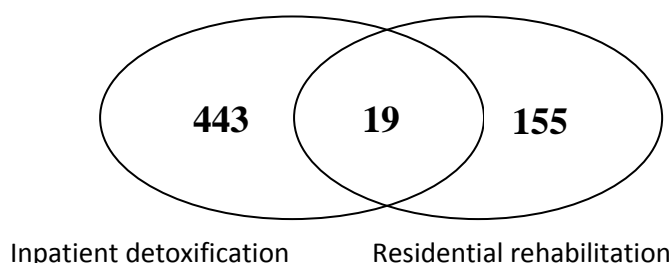


Table 1 displays the number of individuals accessing a tier 4 alcohol treatment intervention by treatment provider within the CLAN area. The majority of individuals (n=369, 57.8%) were either in contact with Pierpoint House (n=187, 29.31%) or Harvey House (n=182, 28.53%). However, an individual may have been in contact with more than one agency throughout the financial year.

Table 1: Number of individuals accessing tier 4 alcohol treatments in CLAN by agency of treatment, 2008/09 (*Please note* data for Wentworth House were omitted from these analyses owing to data monitoring issues but have been included as Appendix 1, page 90)

Agency	Total Individuals in Structured Alcohol Treatment	Percentage (%)
Abbey Gisburne Park Hospital	90	14.1
ADS Residential Service Bridge House	48	7.5
CCDAS	34	5.3
Harvey House	182	28.5
Holgate House	27	4.2
IH Rehab Unit	18	2.8
Littledale Hall	25	3.9
Pierpoint House	187	29.3
Thomas Project	17	2.7
Turning Point Cumbria Residential	10	1.6

Table 2 displays the number of individuals accessing a structured tier 4 alcohol treatment intervention within the CLAN area by PCT of residence. An individual may have been resident in

more than one PCT area during the financial year. Whilst a large proportion of those accessing tier 4 treatment within CLAN were also residents of these six PCT areas, there were also substantial proportions of those in treatment who were residents of Bolton (13.5%) and Manchester (14.2%) PCT areas.

Table 2: Number of individuals accessing tier 4 alcohol treatments in the North West by PCT of residence, 2008/09

PCT of residence	Total (N)	Percentage (%)
Ashton, Leigh and Wigan PCT	7	1.1
Blackburn with Darwen PCT	29	4.7
Blackpool PCT	79	12.7
Bolton PCT	84	13.5
Central and Eastern Cheshire PCT	6	1.0
Central Lancashire PCT	68	11.0
Cumbria Teaching PCT	64	10.3
East Lancashire Teaching PCT	64	10.3
Halton and St Helens PCT	-	-
Heywood, Middleton and Rochdale PCT	-	-
Knowsley PCT	5	0.8
Liverpool PCT	8	1.3
Manchester PCT	88	14.2
North Lancashire Teaching PCT	88	14.2
Sefton PCT	-	-
Stockport PCT	8	1.3
Tameside and Glossop PCT	6	1.0
Trafford PCT	-	-
Warrington PCT	5	0.8
Western Cheshire PCT	-	-
Wirral PCT	-	-
Total (may include multiple areas*)	620	100.0

(Numbers lower than 5 have been suppressed to protect confidentiality of individuals)

* The regional total does not equal the sum of the PCT figures as some individuals may have been resident in more than one PCT area during the financial year but are only counted once in the regional total.

3.1.1 Gender

The majority of individuals in contact with tier 4 alcohol treatment in the CLAN areas were male (n=411, 66.6%, see table 3), a proportion similar to all those in contact with tier 4 alcohol agencies throughout the region (n=981, 66.9%). The proportion of females in contact with tier 4 alcohol treatment varied depending on the type of intervention entered. Females were more likely to enter residential rehabilitation interventions in comparison to an inpatient detoxification interventions (see table 4).

Table 3: Sex of individuals accessing a tier 4 alcohol treatment in CLAN, 2008/09

	Number	%
Female	206	33.4
Male	411	66.6
Total	617	100.0

Table 4: Sex and type of tier 4 treatment entered, 2008/09

Treatment modality	Male		Female	
	Number	%	Number	%
Inpatient Detoxification	304	74.0	139	67.5
Residential Rehabilitation	93	22.6	62	30.1
IPD & RR	14	3.4	5	2.4

The proportion of females in tier 4 alcohol treatment varied by service; over half of the individuals in contact with alcohol treatment in Littledale Hall were female (n= 14, 56.0%) but, in contrast, no clients in contact with alcohol treatment within Thomas Project were female. An individual may have been in contact with more than one agency throughout the financial year.

Table 5: Sex of those in tier 4 alcohol treatment within CLAN by agency, 2008/09

Agency		Sex		Total
		F	M	
Abbey Gisburne Park Hospital	N	30	60	90
Dependency Centre	%	33.3	66.7	100.0
ADS Residential Service	N	21	27	48
Bridge House	%	43.8	56.3	100.0
CCDAS	N	15	19	34
	%	44.1	55.9	100.0
Harvey House	N	61	121	182
	%	33.5	66.5	100.0
Holgate House	N	10	17	27
	%	37.0	63.0	100.0
IH Rehab Unit	N	8	10	18
	%	44.4	55.6	100.0
Littledale Hall	N	14	11	25
	%	56.0	44.0	100.0
Pierpoint House	N	50	137	187
	%	26.7	73.3	100.0
Thomas Project	N	0	17	17
	%	0.0	100.0	100.0
Turning Point Cumbria	N	-	-	-
Residential	%	-	-	-

(Numbers lower than 5 have been suppressed to protect confidentiality of individuals)

3.1.2 Age

The mean (average) age of individuals in contact with structured tier 4 alcohol treatment in the CLAN was 42.1 years; over half of the total tier 4 population were aged 40 years and older (n= 362, 58.7%). The age of those in contact with CLAN tier 4 agencies was similar when compared to all those in contact with tier 4 alcohol treatment throughout the region (see figure 2 & table 6).

Figure 2: Age bands of individuals accessing tier 4 alcohol treatment within CLAN, 2008/09

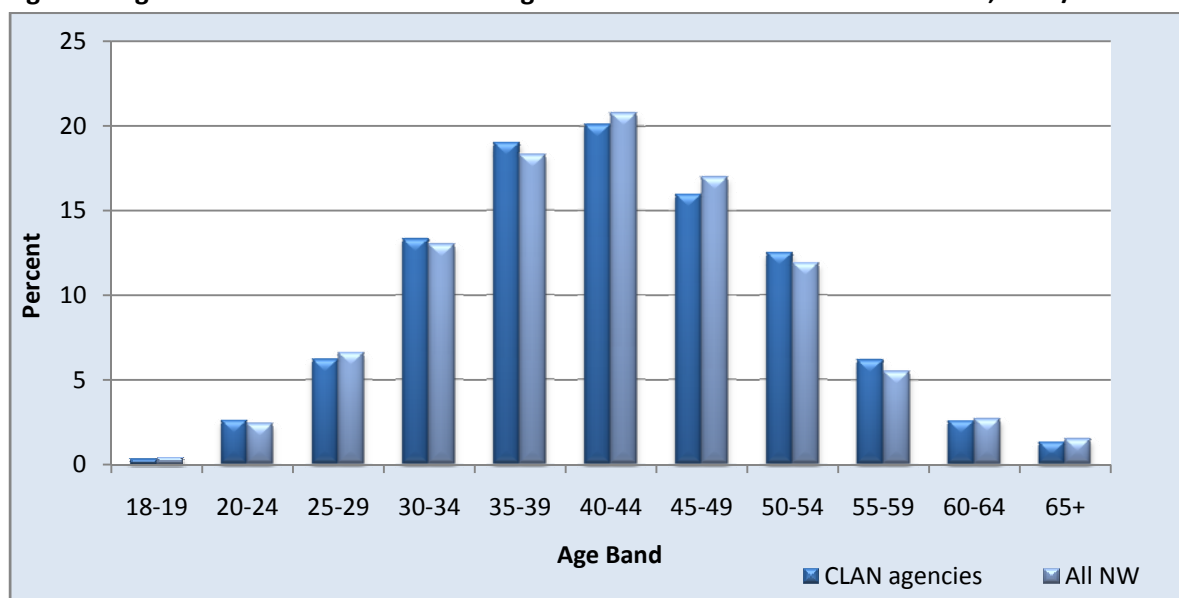


Table 6: Age bands of individuals accessing tier 4 alcohol treatment within CLAN, in 2008/09

Age bands	CLAN agencies		All tier 4 alcohol agencies	
	(N)	(%)	(N)	(%)
18-19	2	0.3	6	0.4
20-24	16	2.6	35	2.4
25-29	38	6.2	97	6.6
30-34	82	13.3	191	13.0
35-39	117	19.0	268	18.3
40-44	124	20.1	305	20.8
45-49	99	16.0	249	17.0
50-54	77	12.5	175	11.9
55-59	38	6.2	86	5.5
60-64	16	2.6	39	2.7
65+	8	1.3	22	1.5
Total	617	100.0	1467	100.0

The average age of those entering a tier 4 treatment intervention within the CLAN was 42.14 years and varied dependent on the service agency entered (see table 7). The average age for those in contact with a tier 4 modality in Inward House Rehabilitation Unit was 35.89 years; in contrast, the average age of those in treatment in Abbey Gisburne was 44.23 years.

Table 7: Average age of individuals accessing tier 4 alcohol treatment by agency within CLAN, in 2008/09

Agency	Average age
Abbey Gisburne Park Hospital, Dependency Centre	44.2
ADS Residential Service Bridge House	39.9
CCDAS	42.0
Harvey House	43.5
Holgate House	39.7
IH Rehab Unit	35.9
Littledale Hall	39.5
Pierpoint House	41.7
Thomas Project	41.7
Turning Point Cumbria Residential	40.0

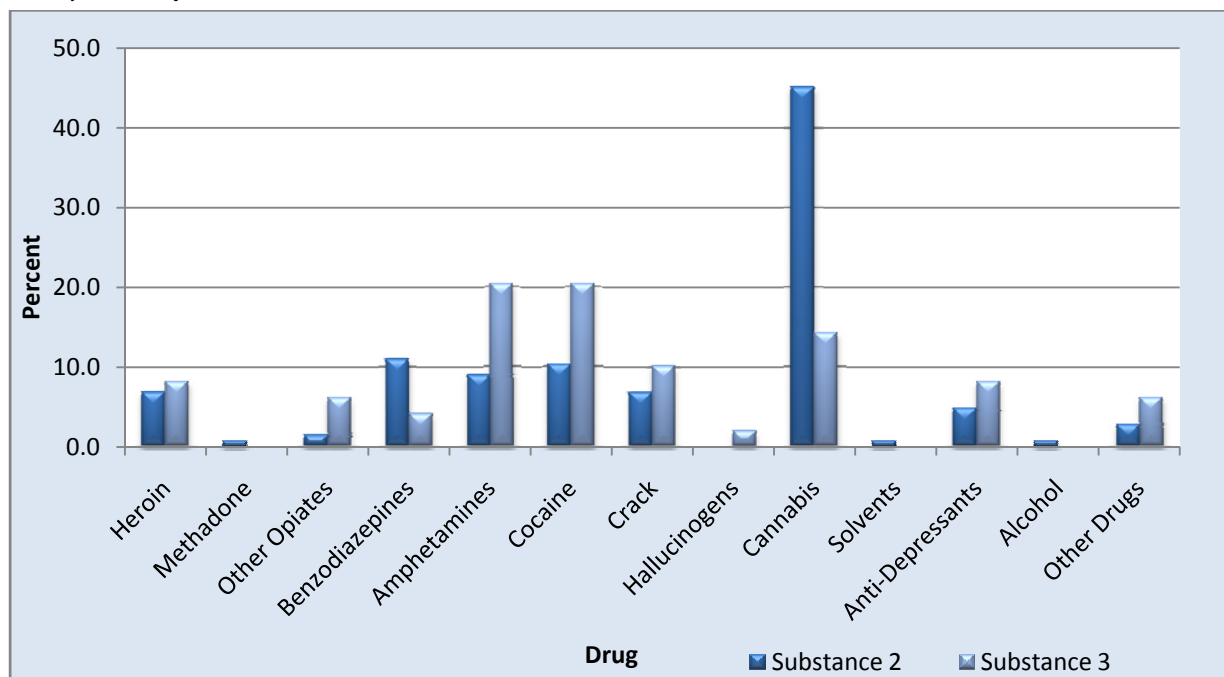
3.1.3 Ethnicity

The majority of individuals in contact with tier 4 alcohol treatment in CLAN stated their ethnicity as White (n=605, 98.1%). This figure is disproportionate of drug use in England (NDTMS, 2008).

3.1.4 Secondary & Tertiary Problematic Substances

The majority of those in contact with tier 4 alcohol treatment in CLAN did not state a secondary problematic substance (n= 471, 76.3%). Of those that stated a secondary problematic substance, 66 individuals (45.2%) stated the use of cannabis, only 7.9% stated a tertiary problematic substance.

Figure 3: Secondary and tertiary substance use of those accessing tier 4 alcohol treatment within CLAN, in 2008/09



3.1.5 Referral Source into Treatment

Table 8: Referral source of those in contact with tier 4 alcohol treatment within CLAN, in 2008/09 (all treatment episodes)

Referral source	Number	%
Drug service statutory	218	33.5
Psychiatry services	-	-
CCA	-	-
CARAT	-	-
Employment services	-	-
Other	214	32.9
Social services	105	16.2
Drug service non statutory	31	4.8
LAC	-	-
Relative	-	-
GP	19	2.9
Community Alcohol Team	5	0.8
Self	46	7.1
Probation	-	-
Total	650*	100.0

(Numbers lower than five have been suppressed to protect confidentiality of individuals)

* The regional total does not equal the sum of the PCT figures as some individuals may have been resident in more than one PCT area during the financial year but are only counted once in the regional total.

3.1.6 Treatment Outcomes

Table 9 displays the discharge reason of those in tier 4 treatment, 100 of the 617 individuals in contact with treatment in the CLAN area were still in their most recent episode of treatment at the end of 2008/09. When only those individuals who had exited treatment were considered, the majority exited their final treatment episode with a planned discharge reason (n=389, 75.2%).

Table 9: Discharge reason for those exiting their final episode of tier 4 alcohol treatment within CLAN, in 2008/09

	Number	%
Planned	389	75.2
Referred on	7	1.4
Unplanned	113	21.9
Other	8	1.5
Total	517	100.0

3.2 NDTMS data - CLAN Residents Only

During 2008/09, there were 419 individuals resident in the CLAN areas in contact with structured tier 4 alcohol treatment. Of these 419 individuals, 276 (65.9%) were male, and 414 (98.8%) stated their ethnicity as White. Over half of CLAN residents in contact with tier 4 alcohol treatment were aged 35-49 (57.5%), with only 9.1% aged less than 30 years of age. As shown in figure 4, the distribution of age between those resident in CLAN and those in treatment in the CLAN area is similar.

Figure 4: Age bands of individuals in contact with tier 4 alcohol treatment resident within CLAN areas, in 2008/9

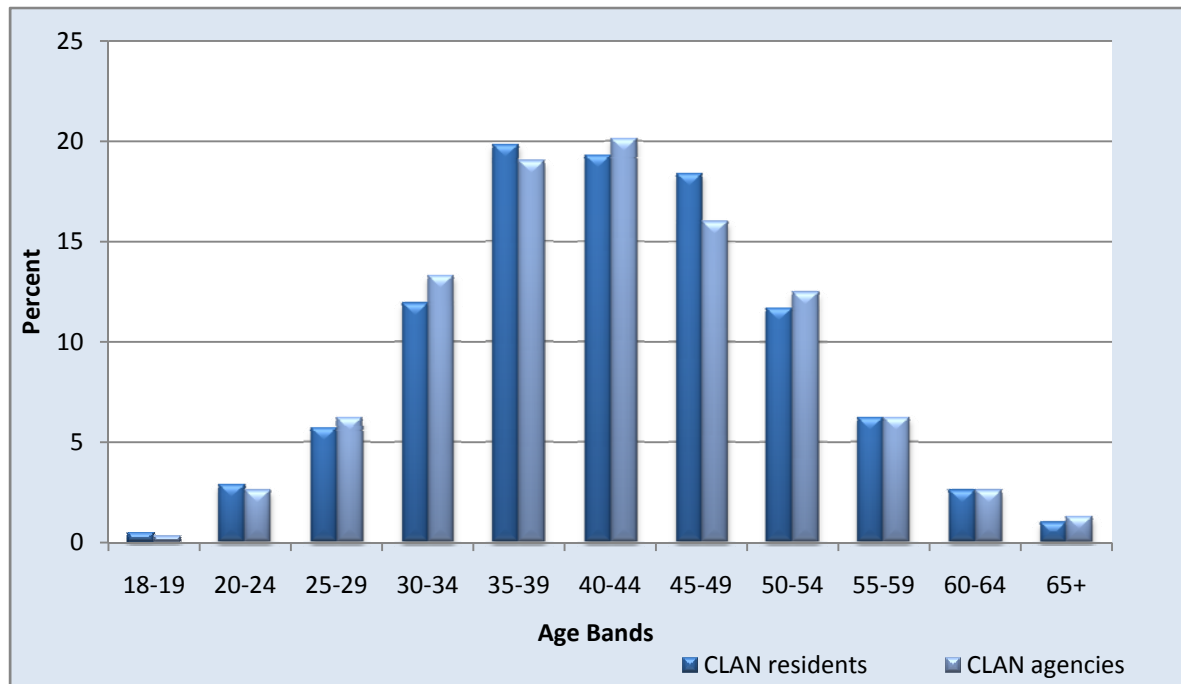


Table 10 displays the agencies attended by individuals resident in the CLAN areas; however, an individual may be in attendance with more than one agency during the financial year. The majority of treatment episodes involving CLAN residents took place within CLAN agencies. However, 26 individuals resident in CLAN had an episode of treatment within Bennett House ADS residential agency in Manchester PCT.

Table 10: Agencies attended by individuals in contact with tier 4 alcohol treatments, resident within the CLAN areas

	Agency	Individuals
Within CLAN area	Abbey Gisburne Park Hospital, Dependency Centre	14
	ADS Residential Service Bridge House	36
	CCDAS	34
	Harvey House	182
	Holgate House	25
	IH Rehab Unit	9
	Littledale Hall	22
	Pierpoint House	62
	Thomas Project	17
	Turning Point Cumbria Residential	7
Outside CLAN area	ADS Residential Service Bennett House	26
	MERC Kevin White Unit	-
	Open Minds	-
	Phoenix Futures Wirral Adult Services	-
	Trust The Process Counselling	-
	Turning Point Ascot House	-
	Turning Point Smithfield Detox	-
Windsor Clinic	-	
Total		445

(Numbers lower than five have been suppressed to protect confidentiality of individuals)

The vast majority of individuals in contact with tier 4 alcohol treatment resident in the CLAN areas did not report a secondary problematic substance (n=347, 82.8%). Of those that did report a secondary problematic substance, 27 (37.5%) reported the use of cannabis.

Table 11 displays the tier 4 treatment discharge reasons for those exiting their final episode of tier 4 alcohol treatment in 2008/09. Of the 419 individuals resident in the CLAN areas, 89 (21.2%) were still in an episode of alcohol treatment at the end of 2008/09. Of those discharged from treatment, the majority had a planned exit (n=250, 75.8%).

Table 11: Discharge reason for those exiting their final episode of tier 4 alcohol treatment resident within the CLAN areas

	Number	%
Planned	250	75.8
Referred	2	0.6
Unplanned	70	21.2
Other	8	2.4
Total	330	100.0

3.3 Service Pro-Forma Data

In this section of analyses, services are categorised as statutory (NHS led), private (non NHS led) and voluntary (non NHS led); however some voluntary services may have links to NHS led services. Statutory services are government funded and required by law to meet given needs; private services are typically business ventures, that may make profit from services provided; and voluntary services are typically not for profit, independent organisations, such as charities, which are managed by unpaid committees or boards and that employ voluntary and/or paid staff.

3.3.1 Descriptive Information

All services recruited returned the service pro-forma, of the 10 services, two were NHS led (statutory) and eight were non NHS led (four private and four voluntary); three were specialist alcohol units and seven were alcohol and drugs units. The average split of the combined units (n=7) was 57.6% alcohol and 42.4% drugs, and the percentage of primary alcohol clients ranged from 40.0%-85.0%. The average fees charged per client per week, across private and voluntary (non NHS led) services (n=8), was £477.50; fees charged ranged from £406.43-£623.00, (NHS led services did not disclose fees). In terms of ethnicity, after White, which accounts the vast majority of clients, the most commonly stated ethnicities were White & Black Caribbean and Not Stated.

3.3.2 Staffing

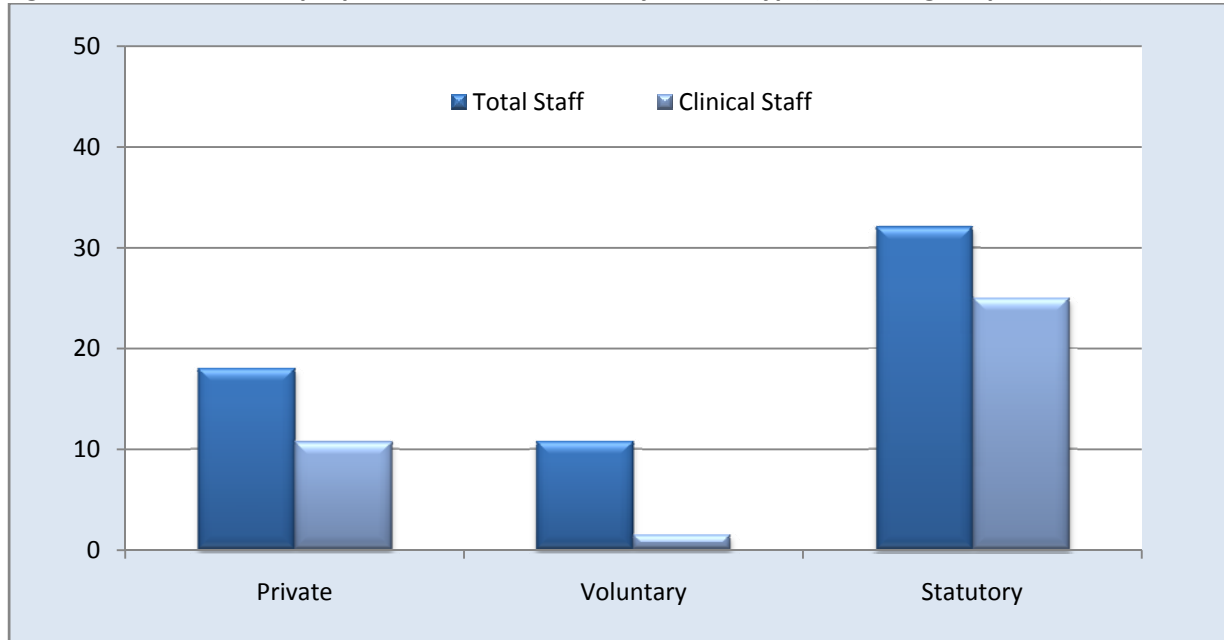
Table 12 displays staffing across all services and percentages of clinical staff, of total staff, by service constitution. As demonstrated, variation was observed between services in terms of total staff and proportions of clinical staff. As displayed one service reported a substantially higher number of total staff than any other service, since the given service reported the total staff operating within the hospital unit and not solely the tier 4 alcohol unit. For this reason, data from this service were omitted from some analyses. As demonstrated, substantially higher percentages of clinical staff, of total staff, were reported from statutory and private services than voluntary services.

Table 12: Breakdown of staffing across all services (N=10)

Service	Staff				Service type	% Clinical staff (inc- service 7)	% Clinical staff (ex- service 7)
	Non-Clinical	Voluntary	Clinical	Total Staff			
1	9	4	25	38	Statutory	78.1	78.1
2	1	0	25	26			
3	3	0	0	3	Voluntary	14.0	14.0
4	2	3	5	10			
5	7	0	1	8			
6	17	5	0	22			
7	54	5	60	119	Private	59.3	53.9
8	3	5	13	21			
9	7	1	0	8			
10	6	0	19	25			

Figure 5 displays the proportions of clinical staff, of total staff, by service type, excluding the aforementioned hospital unit. As displayed, substantially higher proportions of clinical staff, of total staff, were reported by statutory and private services when compared to voluntary services.

Figure 5: Total staff and proportion of clinical staff by service type (excluding hospital unit)



3.3.3 Referral Sources and Non-Completion

Services were asked to identify the five most common referral sources, as displayed, Community Alcohol Teams and Social Services were the most commonly identified referral sources.

Figure 6: Most commonly identified referral sources

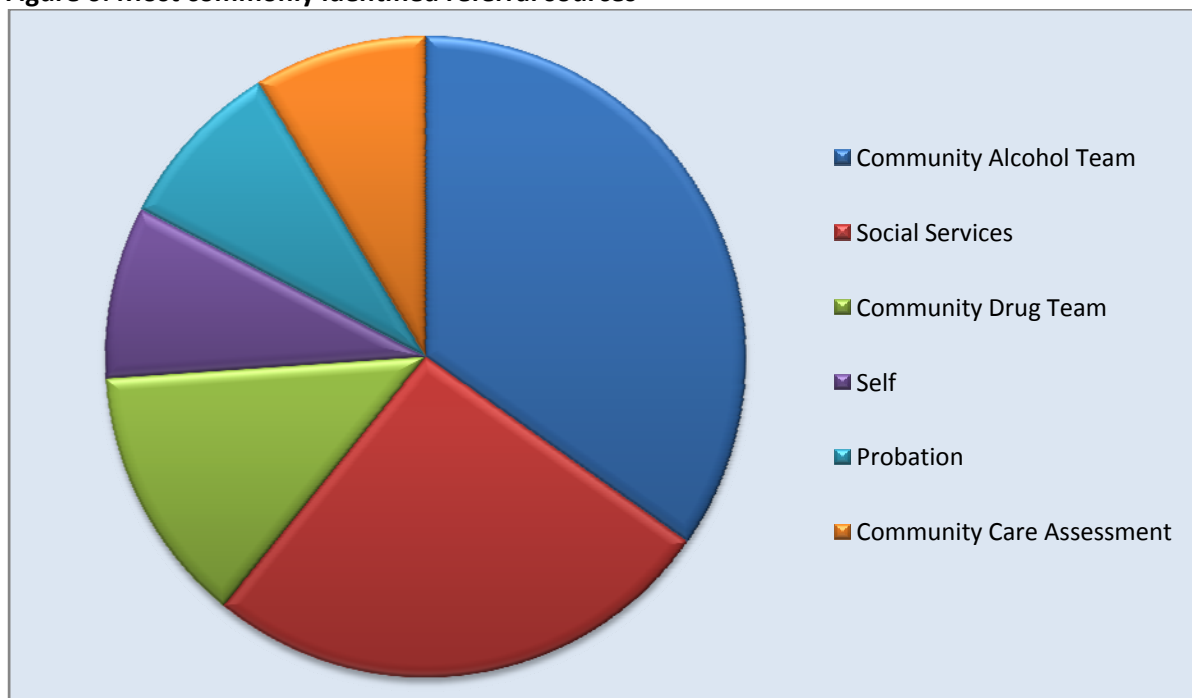
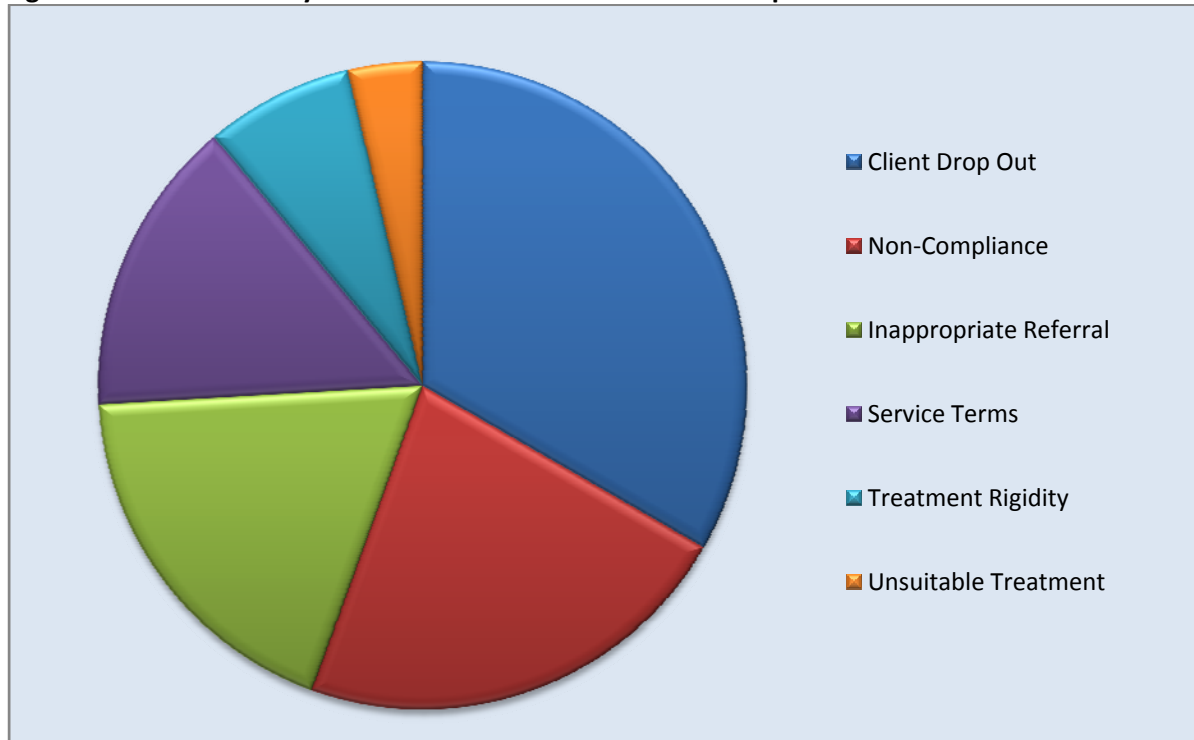


Figure 7 displays the most frequently identified reasons for client non-completion, as displayed, Client Drop Out, Non-Compliance and Inappropriate Referrals accounted for almost three-quarters of non-completing clients.

Figure 7: Most commonly identified reasons for client non-completion of treatment

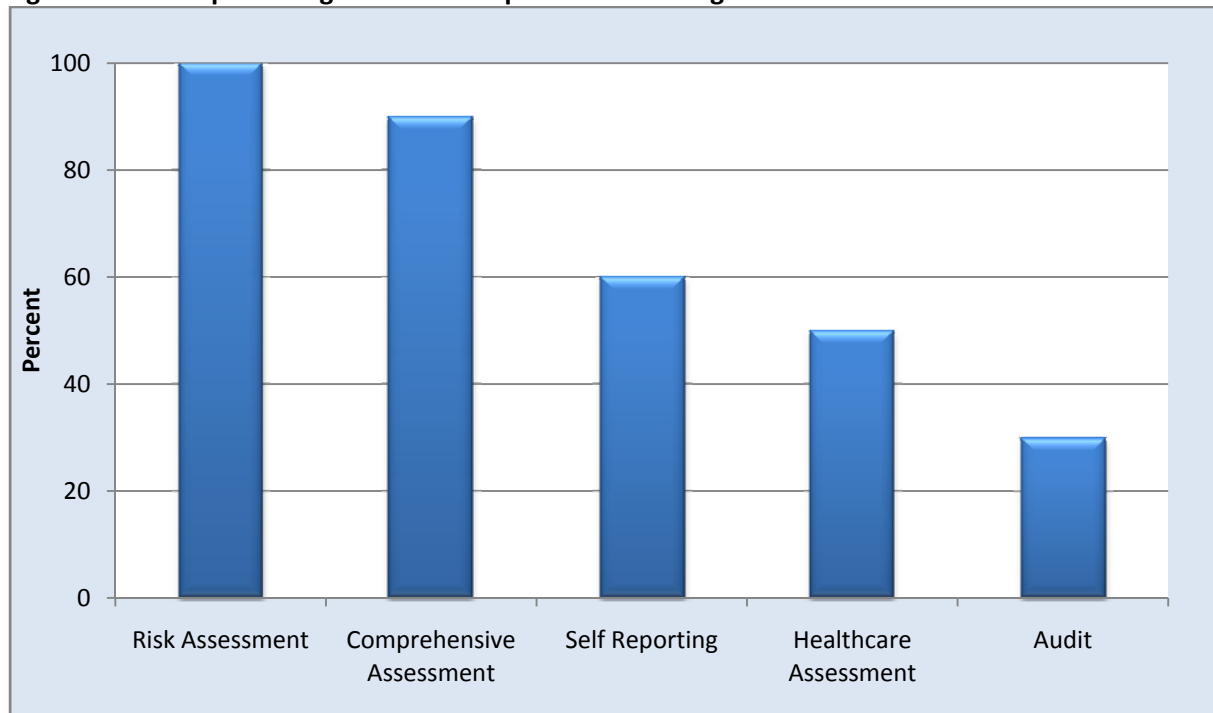


Services estimated between 2.0% and 42.9% of referrals did not attend; the mean across all services was 22.8%. Services stated the most common referral sources, from which clients do not attend were Community Drug Team and Self.

3.3.4 Screening Methods and Activities

Figure 8 displays the percentages of services that utilise particular screening methods. Service types are combined here since there were no observable differences between services of different constitution. Variation between utilised methods was reported, with one service utilising just risk assessments and four services utilising four of the five identified screening methods. The most commonly utilised screening methods were Risk Assessments and Comprehensive Assessments which were used by 10 and nine services respectively (n=10).

Figure 8: Service percentage that utilise specified screening methods



In terms of referral sources, 70.0% and 60.0% of services stated that they accepted referrals from the Criminal Justice System and Dual Diagnosis respectively.

Figure 9 displays the percentage of services that offer facilities for specific needs. Generally few services offer such facilities, while over 40% of services offer facilities for those with physical disabilities, just 10% offer facilities for families or single parents.

Figure 9: Service percentage that offer specified facilities

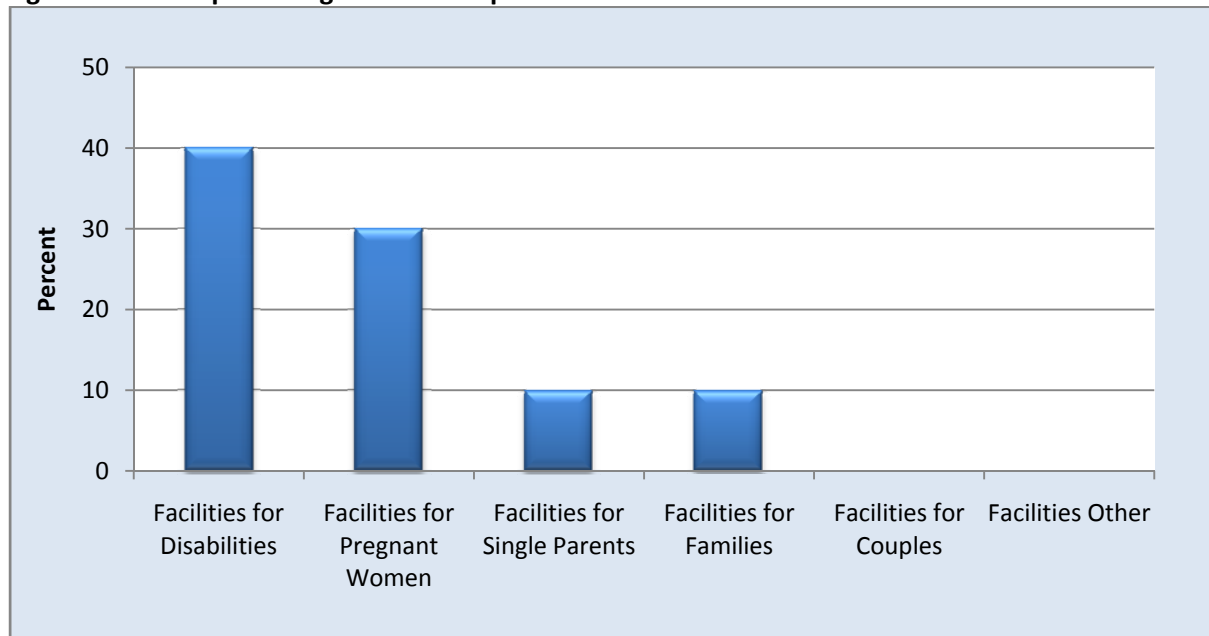
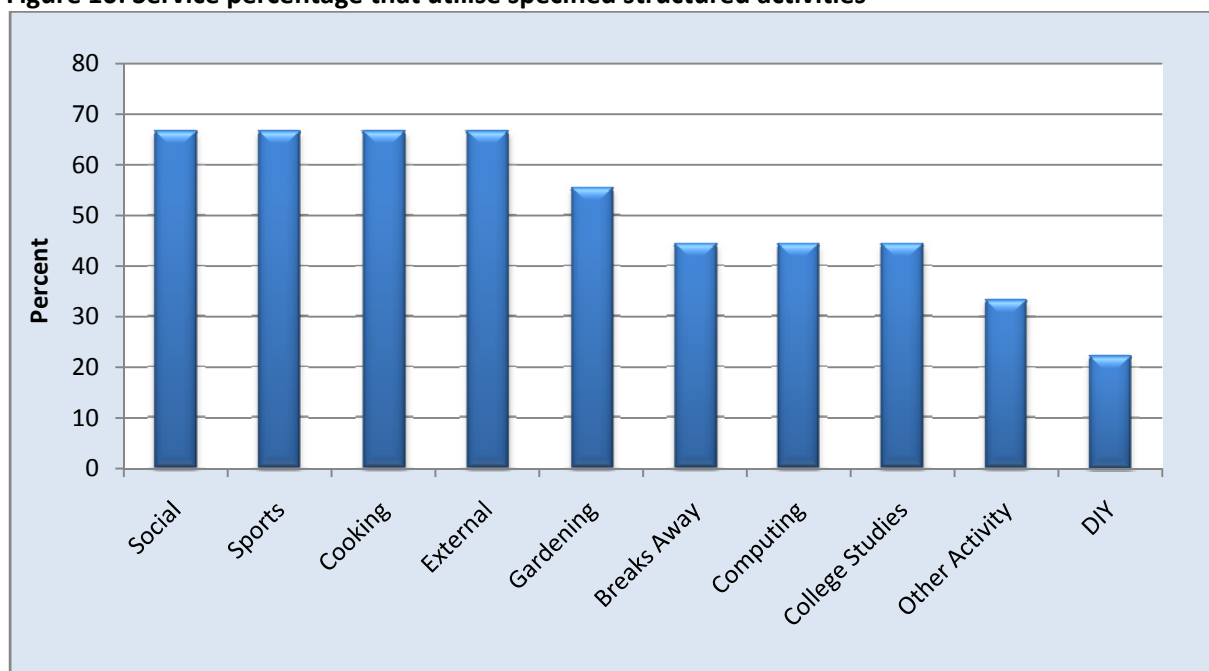


Figure 10 displays the percentage of services that offer particular structured activities. Approximately two-thirds of services provide social, sporting, cooking and external activities; of the other activities, services specified holistic therapy, parenting skills and voluntary work as available structured activities.

Figure 10: Service percentage that utilise specified structured activities



3.4 Service Manager Interviews

Service manager interviews involved representatives of four services, comprising a mixture of NHS led and non NHS led services. Generally broad trends were not identifiable between services of different constitution but variance was observed in individual opinion, regarding issues from policy and practice to optimism about sustainability and the future. The most notable difference found between participating service managers was the estimated operating capacities; while NHS led services described an inability to meet need and long waiting lists, non NHS led services described consistently operating under capacity; in some cases services described operating at 60% occupancy on average.

3.4.1 Funding & Contracting

Service managers described how commissioning of beds was extremely complicated. An NHS led service representative indicated that the majority of beds procured were block contracts but that some spot contracting was useful to maximise capacity. It was described that different PCTs have different service level agreements and that such agreements were partly historical and partly in the process of ongoing development. It was suggested that with degrees of overlap between areas and services, there should be better coordination of commissioning processes. It was indicated that services commissioned were not always 'best for the population' and that there were financial considerations; services not only need to be of a certain quality but are required to have competitive prices. It was suggested that one of the key differences in quality between NHS and non NHS led services, was the distinction between medical management and medical supervision.

"Are NHS led services favourable? I don't know. We are preferred providers because we are medically managed; we detox those that cannot be detoxed in the community. There are many complex issues regarding clients detoxing; NHS provide for that seriousness. Commissioning is partly historical, and partly because we are a preferred provider. The voluntary sector are trying to make inroads into tier 4 provision but can they ever truly medically manage this client group (i.e. provide 24 hr cover)?"

Interviewees described how commissioning processes had changed from operations in the past. It was suggested that less investment was extended to private services in some areas than was historically the case. It was suggested that for some areas it had been cheaper to send clients out of area than to localised services and such services had become redundant as a result. It was suggested that in such cases, cost was the key determinant of service commissioning rather than performance. It was further suggested that development of services relied on funding and that services were more likely to be funded for development if they could demonstrate they were relatively more self sufficient than other services.

It was suggested by NHS led representatives that there were considerable shortfalls in this kind of service provision. It was conveyed that commissioning ought not to be based solely on cost, owing to the diversity and complexity of clients presenting to tier 4 treatments. For this reason interviewees

agreed that 'there is room' for both NHS and non NHS led services, the uses of which would be determined by marrying up the needs of the client to the facilities or specialism of the service.

"We have got to look at needs of a particular population and the advantages to localised commissioning but in terms of buying inpatient detoxification, sometimes shared care commissioning works well; we could feed that back locally. There needs to be models of care for 4 tiers. Everyone needs to work together collaboratively, sometimes people fall through the net and don't get the right treatment but that's for the local D(A)ATs to consider."

"We have to jump through loads of hoops. People don't want to buy block contracts, NHS-led services are guaranteed lots of people to come in but we have to sell the service. We are not operating at capacity; we have 29 beds and 40% are empty at any one time. Tier 4 needs to be balanced between areas with better communication and cooperation among commissioners, care managers...the whole kit n caboodle!"

Interviewees described how recent changes in the National Mental Health definition set were responsible for changes in commissioning responsibility, namely the handover from specialist teams back to PCTs and D(A)ATs. It was suggested that exclusion of tier 4 alcohol (and drug) treatments from the national definition set dictated the change in process. Historically those within the umbrella of the national definition set would operate under a regional framework of specialist commissioning. The proposed removal of the specialist component was generally met with approval by service managers. Rather than gaining benefits from commissioning specialists, service managers argued that the change would 'remove a middle layer' and potentially improve the accuracy of commissioning based on need. Some service managers did express concerns about the proposed changeover.

"We do have some apprehensions with regard to changes in commissioning, hopeful those decisions are based on evidence rather than personality driven commissioning. There is concern that specialist commissioner layer is there because services are high cost and low volume. Tier 4 is a broad brush; we fall in the category of dealing with the most severely complex needs. We are medically managed (complexity of need, including co-existing mental health problems, co-existing physical health problems) we are expected to work with those who are difficult to manage locally. There are concerns that understanding (of services) may be inconsistent; who we are, what we do. There is need to manage services locally but that should be in addition to what we do."

Interviewees agreed that ownership and expansion was needed for the monitoring of commissioning processes, with most agreeing that it ought to be primarily the responsibility of PCTs. It was suggested that monitoring was not undertaken with a long term view and that often commissioning was 'cherry picked' and changed with 'knee jerk reactions'. Interviewees, while expressing positivity about the enhanced responsibilities of PCTs, expressed concern that that changeover may have

detrimental effects on some service providers. It was expressed that services ought not to be routinely commissioned within localities but that constant appraisals should be carried out on commissioned services.

Service managers generally agreed that commissioning processes were convoluted, for example service managers expressed that different areas operated with varied practice and, as PCTs had been redefined over the years, referral responsibility and service catchment areas were not always clear. One specified example related to the overlap between North Lancashire and South Cumbria, where initially Morecombe and Lancaster were grouped with South Cumbria but were later re-grouped with Lancashire. It was suggested that such changes had significant ramifications as to which services could be accessed by residents of these localities. It was suggested that Cumbria PCT had limited access to certain services and that their allocation was small but that it was often overused. Such suggestion implies that needs have not been accurately assessed in some areas, specifically in Cumbria.

“There is a temptation owing to economic climate to cut back tier 4; budgets getting tighter but we are very much in demand, we over-perform with regards occupancy levels, more demand than availability; we can evidence that.”

3.4.2 Service Practice & Development

Service managers generally drew a distinction between medical management and medical supervision, and while some suggested that NHS led services were more likely to be medically managed, interviewees from some non NHS led services also expressed that their treatment services were medically managed. The implication of utilising 24 hour medical management was that services were better equipped to accept clients with more severe and complex physical and mental conditions. The input and ‘round the clock’ access to medical staff, whether doctors, consultant practitioners or mental health nurses, allowed eligibility criteria to extend to a wider spectrum, making such services inappropriate only for those on intravenous (IV) treatment or those requiring highly acute support.

“NHS targets include capacity, waiting times (Department of Health waiting time targets are different to NTA waiting time targets), ability to effectively manage. (There are) lots of other NHS targets such as recording offering of smoking cessation services, making sure people are risk assessed. There is also environmental expectations such as the matron agenda for cleaner hospitals etc. There are lots of targets.”

“Most detox is done in a structured way from tier 3. Risk management processes identify those who may not be fit to be here; the most complex cases, (those with) acute physical problems or chronic physical problems and (those who) need the infirmary of a general hospital, for example severe liver damage or acute liver failure. We do accept those with mobility problems, people with dual diagnosis, lots of people with depression, anxiety, anorexia; even people with enduring mental health problems, if they are stable we look at accepting them with a mission plan. People need to be physically and mentally robust enough to take part in the programme. It's the people at extremes we can't take.”

It was suggested in some instances, that the distinction between medical management and medical supervision guided commissioner preference rather than whether a service was NHS or non NHS led. However representatives of non NHS led services described accepting a narrower band of clients in terms of eligibility criteria. In this case, it was indicated that while referrals were accepted from the CJS, dual diagnosis cases were generally not accepted. Service managers agreed that most services would accept those with poly-drug use, especially if the client could demonstrate relative stability.

“We have an advanced practitioner as our RGM (regional general manager), specialising in physical health care. She has overseen research carried out for screening tools used on assessments to check the likelihood of requirement for acute medical care. We have introduced that across services. It's to do with blood testing and hospitalisation checking, it has removed the need to move people across the sector. We have a virtual ward with Hope hospital, with links to consultant gastrologists, (we have) no need to transfer because of the virtual ward.”*

*Virtual wards are an innovation developed in Croyden and introduced in other areas of the UK, which provide hospital systems and staffing to those with complex needs but without the physical building. In this context, virtual wards can be utilised to accurately appraise available bed spaces and treat less complex clients (Croyden PCT, 2009).

Much of the focus from commissioners and service managers was directed towards inpatient detoxification, which, it was suggested, accounted the majority of tier 4 treatment programmes. Service managers did suggest that residential rehabilitation was under-development and that it could be a useful tool for longer term patients who have ‘achieved a level of stability’. Such programmes, it was suggested were much longer and useful for clients to ‘get to know themselves’ mostly through psycho-therapeutic processes.

Interviewees suggested that in some cases, services were not fit for purpose. While some managers described ongoing developments or plans to move from one site to another more appropriate location, others expressed less satisfaction at their services’ facilities. It was suggested that such translocation was difficult to manage and could potentially destabilise services but that in the longer terms, it would be imperative for the effectiveness of a service. One particular benefit of a described

move was that tier 4 alcohol and drugs units could be combined, allowing a joined up approach to treating those with poly-substance use. Other managers expressed concerns that services may not be entirely fit for purpose but that acquiring funding for translocation was not a realistic possibility.

“When we move we’ll have 36 beds in total; currently there are 15, 14 commissioned by Greater Manchester West, the other is an overuse bed. This number doesn’t reflect need; it’s not based on needs assessment but on history. We have the same number of inpatient (tier 4) beds as before 1990 and we know alcohol problems have increased massively. With drugs for example there are more beds than are commissioned so services could increase occupancy where necessary with commissioners. In service ‘X’ it is physically impossible to get more than 15 people in the unit, we have indicated the supply and demand issue; we know we could fill service ‘X’ three times over.”

Service managers discussed the role of tier 4 services within the care pathways, with most managers agreeing that service effectiveness would be improved with enhanced links from tier 3, wraparound services and aftercare or community services. It was stressed that services were commissioned for the duration of an individual’s stay, it was suggested that outcomes beyond this duration was out of the control of the service. Such interviewees expressed that referrers were chiefly responsible for ensuring smooth progress from pre-admission to aftercare and wraparound services.

Some interviewees expressed that services could perform better with regards to making the transition from tier 4 services back to the community, even if only in terms of monitoring information and service user feedback. Previous feedback highlighted the need for specialist counselling, especially if an individual is the victim of abuse or bereaved. It was suggested by such interviewees that the service did have a responsibility to actively engage in the handover and exchange process with the referring area.

“We have policies for planned and unplanned discharge. Sometimes we can persuade people not to leave but often the decision has been made. Maybe peer groups, or next of kin or care managers can help; we try to keep them to prevent unplanned discharges. If someone is intent on leaving we usually try to get them an appointment to see somebody, usually their care manager. We also give harm reduction information to clients pre-exit or for services such as Alcoholics Anonymous or Narcotics Anonymous meeting points. We also give information about safer practices (e.g. not drinking to same level as before they came in).”

Interviewees discussed elements of standard practices; while detox length and residential rehabilitation programmes varied to an extent, most interviewees were less concerned with programme content or structure but identified the nature of the service user as a key determinant of treatment success. Interviewees suggested that treatment effectiveness was more dependent on the individual and their journey back to communities than the structure of a detoxification or the standard practices of a service. Interviewees agreed that standard practice had been broadly defined

and was adhered to in most cases; such practice includes the use of information packs, supplementary educative elements, robust policies for planned and unplanned discharges and close coordination with care managers.

Interviewees described several barriers to treatment effectiveness, such as the emphasis of national policy, local and umbrella commissioning processes, disproportionate use of services by area and services operating substantially under or over capacity. Another barrier identified by multiple interviewees was that 'there is quite big and rapid staff turnover' among referring agencies. The importance of developing relationships with commissioners and referring agencies was emphasised; it was further suggested that owing to changes in policy and staff turnover respectively, consistency was more difficult to achieve.

"One major barrier is the lack of understanding about what we provide. Lots of care managers have personal choices that they put on to the clients, it's not impartial information all the time."

"Localised commissioning would be a big benefit, lots of commissioners have not worked in substance use and just look at it from a monetary point of view; what's cheapest. If funding choices were given back to people who work with clients it would have massive impact."

3.4.3 Referral Acceptability

Service managers agreed that not every service would necessarily be capable of accepting a broad spectrum of clients depending on facilities, capacity, staff specialism and level of medical supervision or management. While some services stated that there were very few referral types that they would not accept, others expressed they would only accept relatively straight forward referrals, for example referrals from the CJS, clients with a history of offending, dual diagnosis cases, clients with poor physical health, clients with gender specific needs, pregnant clients or those with dependent family, were generally not accepted by most services.

While referral appropriateness is generally guided by the policy of a particular service, service managers agreed that acceptability is judged on a case by case basis and in some instances appropriateness is assessed by use of one-to-one interviews between the service manager and the client. One interviewee estimated that approximately 85% or 90% of referrals were appropriate from the outset, describing how referrals were processed by an administration team, which filtered out certain 'oversights' before paperwork is passed to the service manager to make the final decision. It was suggested that if a referral is deemed inappropriate at this stage, the manager will attempt to refer the client to an appropriate service, whether a hospital or another tier 4 service; it was suggested that managers are hesitant to 'just say no'.

Interviewees described how quality of referrals varied between areas and that some areas would consider community detoxes (following NICE guidelines) and alternatives to tier 4 care, while others would just refer all cases of a certain nature to tier 4 services. It was suggested that such exploration

of alternative options relied upon close working relationships between tier 4 and community services, which are not well developed in all areas.

An interviewee from an NHS led service expressed that alcohol referrers (when compared to drug referrers) tend to be nurses or social workers, who would be more likely to consider and facilitate community detoxes. It was further suggested that such workers may be less likely to have a clinical background and may be more compliant with client wishes, even if referral to tier 4 services was not the most appropriate course of treatment. It was suggested that a higher level of clinical expertise within drug referral sources improved the percentage of appropriate referrals into tier 4 drug services.

A representative from an NHS led service described plans to increase capacity and increase bespoke facilities, including private rooms for those with specific needs. While other service representatives expressed a desire to expand and improve facilities, financial constraints were identified as a major barrier. Interviewees also suggested that unless a service can ensure a smooth transition across sites, service may become destabilised. Such a smooth transition would usually imply a degree of overlap between sites so that moving services would be less disruptive but it was suggested that the concurrent occupation of two sites is costly and difficult to manage.

An interviewee from a non NHS led service expressed that often they were not able to accept the most complex cases and described how alternative arrangements were made for clients presenting with particular specialist requirements. For example pregnant women, it was described, could be referred to a specialist community service but only in the early stages of pregnancy. Other client types, such as offenders or referrals from court, were further referred through links with probation and community teams. It was suggested by a representative of a non NHS led service that such referrals were not accepted since often clients from such sources lacked motivation and could have a disruptive effect on other residents.

“Which clients bounce back? We risk assess and take on an individual case basis; we do take people with a history of violence. We have one coming back who assaulted a member of staff, we just make sure there are packages in place to ensure good management of these individuals (including our multi disciplinary team). One client was refused entry as result of us not being gender specific, owing to the inappropriateness demonstrated to the opposite sex (by the individual).”

“Eligibility criteria, standard, quality and number of referrals vary considerably; it’s something we have shared with specialist commissioners. It’s multi faceted; one reason for variation is the availability of alternative options within our locality. If you have an area with well developed community detox, that option can be considered before moving on (to tier 4). That’s not available in every area and if it is available, it may be under developed.”

3.4.4 Data Monitoring

Service managers suggested that data monitoring was routinely carried out and that the reporting of such information had value in ascertaining treatment effectiveness. Service managers described a range of monitoring process; all interviewees described submitting to NDTMS, others also described submitting to third party monitoring bodies facilitated by commissioners, while others described recording information using their own monitoring systems. Some interviewees expressed relatively less enthusiasm and belief in data monitoring processes, with some expressing that reporting and feedback information was seldom used constructively. It was implied that inconsistencies exist within monitoring processes, which make consistent and accurate reporting of information more difficult. Service managers agreed that consistent monitoring templates would be welcomed by services and commissioners.

“We have started our own evidence based outcomes. We have a working group looking at all our outcomes. For example, for detox, what do we want to measure?”

“We send information to NDTMS, we also feed into performance monitoring which is fed back to commissioners. There is ongoing dialogue with commissioners; we are consciously monitoring performance. We have mechanisms in place within the trust care; they are kept on the dash board.”

Interviewees described difficulties in recording monitoring information owing to a division of responsibilities within a service. In one instance the service was described as being split between prescribing services and residential rehabilitation. It was expressed that inpatient detoxification could fall into one category or another; mutually exclusive categories would provide more robust data it was suggested.

Services generally inferred that the most heavily utilised data was that which had been recorded internally. Often feedback for planned and unplanned discharges is recorded with the assistance of care managers, which are used to make improvements to minimise risks of early discharge in the future. Interviewees from some services expressed an ongoing investment to monitoring as much information as possible but described a lack of coordination with commissioners, a lack of shared priorities in terms of what information is recorded and a lack of consistent templates as major barriers to the monitoring process.

“We have questionnaires, clients fill them in monthly and on discharge; (for unplanned discharge) the admissions team gives it a few days and then rings that persons’ care manager for feedback, we have community meetings each Monday where concerns are aired.”

3.4.5 Evidence Base

Interviewees expressed shared commitment to developing treatment and care pathways by developing and utilising an evidence base. It was expressed that detox programmes were often developed in line with the medical evidence and that most tier 4 treatment pathways were under the scrutiny of medical research and were constantly redefined in keeping with such information. However, interviewees expressed that psycho-social interventions were less robustly researched than other aspects of tier 4 treatments, such as inpatient detoxification.

‘Node Link Mapping’ was highlighted by one NHS led service representative as providing a useful blue print for one to one work and group programmes. Node Link Mapping is a technique of visually representing aspects of treatment in order to improve client comprehension. It was however expressed that such interventions were heavily reliant on the skill, and expertise of the facilitating staff, including their level of training (such as with programmes like Cognitive Behavioural Therapy (CBT) and the International Treatment Effectiveness Programme (ITEP)). Such training and expertise were suggested to be equally important as the evidence base of such interventions within the psycho-social context.

“Like everyone, we are gathering an evidence base which is an ongoing process. We work in an evidence based way for all psycho-social interventions and detox; it’s all evidence based. There is no manual as such, just a lot of information. In the future maybe we will develop that side of things.”

“It depends on the individual; you can work out the characteristics of those who will have success or failure but it might not be until you are mid-treatment before you realise it might not be for them. We would not carry on treating somebody if it wasn’t going to do them any good or be of benefit to them. You are setting them up to fail and this causes longer term issues or can set them back further. We are here to help not hinder.”

“We ask clients all sorts of questions and get feedback about what’s useful etc. We are also developing our service user programme, what could we change or improve? We send questionnaires to the audit department and we get a report. We use (ITEP) International Treatment Effectiveness Programme, as a core mechanism. We get feedback from that, it seems to be working.”

“We produce monthly performance reports, which detail waiting times etc and is split by age, gender, ethnicity, referral area, number of unsuitable referrals, why they have not met eligibility criteria, why referral was inappropriate. We comply with NDTMS dataset, we record reason for discharge whether planned or unplanned, length of stay, where did they go. We record lots of data!”

Interviewees concluded that, while national policy may lead and encourage performance driven practice, it was the responsibility of the service to take the initiative in developing evidence based manuals and utilising them to improve the efficiency and effectiveness of treatment programmes.

3.4.6 Modulation & Community Based Treatment

Interviewees discussed the possibility of reducing the burden on tier 4 services by either treating a proportion of presenting individuals in a community setting or by modulating aspects of tier 4 services so that clients utilise provisions based on the recommendations of their care manager or service manager. Interviewees concurred that, in most cases, community based treatments were inappropriate for dependent and chronic alcohol users since detoxification is abstinence based; it was suggested that reaching abstinence within a community setting was difficult, since not only would the client be more likely to relapse within their 'normal environment' but that individuals would have to be drink (or drug) tested every day. However, it was suggested that some agencies ran high standard community based 12 step abstinence based day programmes but that such programmes would only be appropriate for a small percentage of the most stable clients.

"We modulate anyway; each person is individual so we try to mould treatment around them; we individualise the programme while they are attending. It's not simply a 12 week course but a journey through treatment to see how addiction has affected one's life and the lives of others."

(There's) no point doing group work or on an area that is not relevant, because they won't engage, you'd be wasting their time and the money of the person who is paying for them. We do get very good feedback from clients who say it works for them, 12 steps doesn't work for everybody; some do and some don't."

Interviewees from all service constitution types agreed to the idea of modulation of services in principle, although described varied commitment to breaking down service menus and individualising treatment journeys. Interviewees indicated that modernisation of tier 4 was a prerequisite for further individualisation; it was suggested that breakdown menus and a choice of modules could be considered but only when the cost effectiveness and efficacy of the treatment had been demonstrated. It was also suggested that associated services and aftercare were critical to treatment but are not well developed in all cases.

3.5 Service User Interviews

Service users discussed many issues relating not only to tier 4 service provision but also the personal ramifications of dependent or chronic drinking. The key message drawn from these interviews was that alcohol affects individuals in different ways and, when coupled with underlying physical or mental health issues, it is most often the level of individual attention and the attitude of a patient that determines treatment success. However, interviews in this case are with service users who successfully moved to and were stable in abstinence.

3.5.1 The Nature of Alcohol Use

Service users discussed their personal circumstances and root causes of their past addiction to alcohol. Each interviewee described adverse circumstances, which in some cases were extremely severe and led directly or indirectly to their alcohol use. Interviewees described how their alcohol use had escalated and identified 'triggers' which had led to lapses or relapses. Interviewees commonly had started drinking at a young ages and described being 'different' to their friends when they collectively reached the legal drinking age. Several interviewees also described addictions to drugs and described how patterns of substance use are often interchangeable and treatment services cannot address isolated problems but would benefit from considering the varied facets of a client's substance use and general health.

"I know people who come home and have a big glass of wine every night, just to wind down, and they ask if they have a problem. I say try stopping and see how easy it is."

"Those people who drink Friday, Saturday and Sunday and are back at work Monday, have the addiction but just for the weekend. Being dependent on it even for the weekend, in my mind, means you are an alcoholic."

"It finally clicked that I was depressed before I drank. I didn't know myself."

"I was using substances to make myself feel like I was in control when in reality things were falling off the edge. It was getting worse and worse but taking substances to make me feel I was in control."

"You could argue they (weekend drinkers) are coming down Tuesday and Wednesday and they might be back at it Thursday. But we (as society) are accommodated to meet these needs." "The government recommends you are safe to have a glass and a half of wine every night, why would you want that every day? If you did I would ask why (beginnings of a problem). It's the road to ruin, it becomes a habit and then an addiction."

While some described creating problems with their families, others described isolating themselves from their families and society in general. Interviewees described 'holding jobs down' while their drinking escalated but they became more aware that their drinking was problematic when issues

began to encroach on their lives. Interviewees described inefficiencies at tier 3 level, describing how GPs were unhelpful in the most part, often just giving the patient a number to call. Multiple interviewees described failed attempt to self treat, by cutting down their drinking or in one case by using other substances to address the symptoms of their drinking.

Interviewees described various routes into treatment; while some were referred by their GPs others were helped into services by their families; while some of the interviewees received more than one detox, others became abstinent after their first period in tier 4 care. However, all interviewees agreed that their alcohol use was never the same after their first inpatient detoxification. Interviewees described how detoxification in a tier 4 setting was only the beginning of the journey to abstinence and that upon discharge 'you face an uphill battle but one that can be won'. Interviewees that had been through multiple detoxes described the situations that led to relapses; 'everyday' situations that non-drinkers would not recognise as potential triggers for relapse. Such situations or triggers included events such as Christmas parties and, as one interviewee described, advertising including television commercials.

"Between the ages of 11-31 I was under influence of substances. After the first initial detox it was like an awakening, for all those years I had just been functioning, I was totally de-sensitised to everything, I remember being sat in the detox being amazed and mesmerised by a sandwich. I was never the same again. I did relapse a number of times on alcohol and substances (which led me back to service 'X') in 2008 I looked at my behaviour surrounding alcohol and never really addressed my use of substances; I didn't see those as my problem. From the first detox things were never the same again. When I picked up the alcohol again I knew straight away it was the wrong thing to do. As soon as I relapsed I knew I wanted to get back to where I was."

"You need more because your tolerance builds up, you have to drink in the morning to relieve your depression, you are fighting depression and for some people it's too much because their life is a wreck. You need more and more alcohol; depressed and drinking a depressant."

"I am of the impression now that all substances are mind altering. People are able to jump ship depending on the political climate. People are of the impression that there is a difference between alcoholics and drug addicts and the truth is there is no difference, they are all just substances. Whatever the substance may be, be it alcohol or drugs it destroys us and it takes over our lives."

Interviewees commonly described channelling their energy into something productive upon reaching abstinence. One interviewee described attending support groups, contributing to community based interventions and, over a period of three years of abstinence, becoming a fully qualified teacher. However, such periods of stability may not prevent further relapses and it was not until the fourth detoxification that the individual described feeling secure in abstinence. In this case it was extremely poor physical health that finally led to a successful detoxification.

Interviewees described the importance of setting goals upon discharge but that targets and goals have to be realistic; it was described how relapses could follow the 'disappointment of not reaching targets'. Interviewees described how, unlike addiction to heroin for example, one's tolerance for alcohol does not diminish after a period of abstinence. It was suggested that a consequence of such a tolerance was that chronic drinking, rather than steadily increasing use, would follow a relapse. Interviewees agreed that an addiction to alcohol is extremely harmful to one's self, one's friends and family and 'ripping families apart'; the harms it was described were not confined to one person but the people they knew and wider communities. Interviewees agreed that the two overriding of feelings of dependent drinkers were loneliness and of worthlessness.

"Being a recovered alcoholic is like being bi-polar, the highs and lows are exaggerated. It's about the balance. I know a girl who goes to Alcoholics Anonymous twice a day, seven days a week; it's like, she's addicted to meetings."

"There are a lot of drug users who drink alcohol because often we transfer from one thing to another (for me particularly). That's why I look at behaviours now; we transfer from one behaviour to another. When I was with anger I would pick up cannabis for example. I was medicating myself to calm down or so I thought. The fact was I just opened the gates to go through every other substance and say 'at least I've not had a drink'. At that stage I prioritised alcohol above drugs because I went to an alcohol only service. If my substance use had been recognised at the time I think my treatment would have had a different emphasis."

Interviewees described how, after three or four weeks without drink (or drugs) there was no physical addiction only a psychological challenge. For this reason interviewees described feeling extremely guilty upon lapse or relapse, not only for 'letting themselves down' but also for the people who worked with them through detox. Service users described how, in one sense the first detox is the hardest because you are breaking an addiction, in another sense detoxes get harder because you feel 'embarrassed to be back'. Interviewees described how care workers can be very understanding and one interviewee recalled that he was told 'it doesn't matter if you come in ten times; you will get there in the end'.

Service users described wraparound services as being crucial to the treatment journey; describing supportive services, such as Turning Point, SMART and supportive housing, as 'levers to stay abstinent'. One interviewee described a passion for such support and detailed how he has helped feedback into such services.

3.5.2 Individual Complexities

Service users indicated a strong influence and key determinant of treatment effectiveness was individual state of mind, outlook and attitude. It was commonly agreed and heavily emphasised by interviewees that regardless of policy, practice, service facilities, levels of medical management or

application of the evidence base, if an individual is not mentally prepared and determined, treatment success would be less likely to achieve.

“They are marvellous at service ‘X’, I think the detox is easy, it’s the aftercare that is so important. The coming to terms with it, realising you must not drink again, not wanting to drink again and give something back to help other people because it’s a very lonely place, a very lonely place.”

“By the time you get there you’ve lost everybody; you’ve lost yourself.”

“Alcoholics can get their booze from a corner shop; drugs are not accessible in that way. Often alcohol users are withdrawn, isolated, timid and scared. By the same rule people with alcohol issues can have a calming effect on people with drug issues. I think they work very well together.”

Interviewees described the importance of having a mentor, an inspirational figure to guide them and restore belief within the client that they could move to abstinence. It was also agreed that without such inspiration, owing to ‘generally depressive natural of alcoholics’, many people would not find the strength to move to abstinence on their own and without such support. Interviewees described how despite good practice models, developed facilities and strong educational messages, often treatment success or the potential for treatment to have success is determined by the skill or commitment of care workers and support staff.

“Service worker ‘X’ gave me two things when I first went into detox unit; faith and hope. She had faith in me and hope for me, and that was priceless. Somebody, for the first time in 20 years actually believed I was going to be alright and told me I was going to be alright.”

“I stayed in service ‘X’ for three weeks and realised I should never drink again; I’ve been off it for four years in February. I want to put something back now, we go to service ‘X’ every Thursday and Saturday, it helps me to keep sober.”

Interviewees described the emotional changes that occur upon moving to abstinence. Interviewees agreed that sobriety is not easily sustained and an individual will experience lots of ‘ups and downs’. It was suggested that it is important to recognise such ‘ebbs and flows’ for what they are and have the foresight to know ‘it’s ok, it’s just a down moment’.

On poly-drug use, the interviewees who had engaged in use of many types of substances agreed that often individuals try to deal with a drugs problem by drinking, but that such behaviour will become habitual and in due course you may re-present to services for dependent alcohol use. It was suggested that addictions may be switched or transferred, interviewees who had been abstinent for a prolonged period described feeling addicted to certain everyday things, and doing them obsessively. It was suggested that once you have been fully dependent on something it is very

difficult to fully remove the addictive tendencies. Conversely it was suggested that having led extremely chaotic lives, ex-dependent drinkers were often extremely ordered in their new lives and that such order helped individuals to remain calm and feel in control.

“Unplanned drop outs are because they (the clients) are not ready. (It's a) personal thing. There is also a lot of outside influence as well. Insulation does not help, giving families and carers insight and education does (help). Service 'X' have set it up, it can be a massive tool. This is not an individual issue, it tears families apart; one individual can turn the whole dynamic upside down. People don't understand (they say) “just stop”. Families drop them off (at services); “ok see you in 3 weeks...now you've stopped drinking, keep it up”. But we are coming back out (into community) to all these issues. It's like walking into a war zone.”

3.5.3 The Nature of Services

Interviewees generally described tier 4 alcohol treatment to be a 'completely essential' service. It was suggested that community based detoxes or interventions were not enough and that detoxes in hospital settings were not always sufficiently educative. Interviewees described a points scoring system which operates to determine the level of alcohol dependence upon presentation to services which precede tier 4 treatment. Interviewees described inaccuracies with this system, the main criticism being that dependent drinkers, ideally suited to inpatient detox, may not score the required points and may not receive an appropriate referral.

Interviewees described long waiting lists in some areas and for some services. One interviewee described how he had been placed on a waiting list for seven weeks, by which time had had taken himself out of area, got referred to another service and completed a three week inpatient detox. This particular interviewee required only one detox to successfully move to abstinence. Interviewees identified such time periods as crucial to overall treatment success since, owing to the influence of an individual's mind set, if a person is ready and willing to undertake a detox and is made to wait an unreasonable time, they may lose their motivation, impetus and momentum.

“I didn't need residential rehabilitation, detox was the main point. When I left I never wanted to go back to detox; when you've been through it once, the second time you don't want to go through it again and a third time you know what's happening from start to finish, you are just going through the process and motions. The first time is the most important.”

“After that first detox it's never the same, you have a glimpse albeit only for four weeks, you remember (the experience). That seed gets planted, you know that's where you want to be, that's the reason we walked in, in the first place. One of the biggest things I remembered from my first detox was that I was not on my own with it, that peer group, the fact that there are other people who feel the way I was feeling. I was accepted and not ostracised, I felt like a human being again.”

Interviewees described how 'it's very hard to take the first step' but that once you have the is an increased likelihood that one can move to abstinence, even if it is not after the first detox. Clients estimated success rates of first detoxes to be as low as one in ten but suggested that 'most would make it in the end'. It was suggested that this rate was a potential problem in demonstrating cost effectiveness of tier 4 services but that there was no other way to 'give people their lives back'.

"The key point is that the others (unsuccessful clients from first detoxes) will make it eventually, it might take fifteen years; your life is wasted and you want it back. If you don't stop, it becomes terminal."

Interviewees stressed that often substance use problems were co-morbid with mental health problems and that treatments could not address one without addressing or considering the other. It was suggested there was importance in addressing the root causes of substance use and identifying which problem came first. Interviewees suggested that drinking was closely linked to depression and multiple interviewees stated that they believed themselves to be depressed because they drank. Interviewees described that, ideally services would address both together but that the effect of one on another is not uniform among individuals. For example, some may feel they require alcohol to address their mental health problems while other feel their mental health problems are symptomatic of their alcohol use. A joined up approach to treatment was strongly recommended by all interviewees.

3.5.4 Barriers to Treatment Success

Service users described personal and broader barriers to effective treatment. As previously mentioned, interviewees described the role of staff as crucial to treatment effectiveness, in the same way that committed staff can provide inspiration, less committed staff could prove obstructive to successful client completion and stabilisation.

Interviewees commonly agreed that waiting times had the potential to be a major barrier to treatment success. One ex-user described how he was placed on a waiting list for six months in his particular area, explaining that there is a backlog in the system and inpatient services are like 'one in one out'. Interviewees described how individuals could be back at home or on the street drinking within the same day of having been put on a waiting list. Interviewees described how there were different systems in different authorities and the lack of consistency had led some treatment seekers to take themselves out of area in order to receive better care. It was suggested this was inevitable if needs were not met.

"At a point in their substance use they are ready to access services and make a call but it might be three, four or six weeks before you are given a bed. You get a letter saying now you can come...you might not be ready then."

Interviewees described feeling stigmatised by the general public, not only as dependent drinkers but also as recovering and stable, productive members of their communities. Interviewees suggested that those with strongest perceptions of stigma were often those with similar problems. While this is a subjective view, it was further suggested that alcohol problems pervade more families than services may be aware of and that often problems are deflected or ‘covered up’. Interviewees suggested that the ways people structure alcohol around their lives were the best indicators of a problem or the beginning of a problem; for example if one consumes their first drink at the same time every day, if drinking prevents them spending time with friends and family or if they have difficulty going through a day without a drink. It was suggested that waiting for the weekend to binge drink is often the way a dependency can begin to develop and that just because there are no life changing problems arising, such drinking may still be problematic.

“People say once and alcoholic always an alcoholic; I think there is a cure.”

“There are strong perceptions of stigmatisation. The public say ‘just stop drinking’, I don't think the public understand addiction whether it's drugs or alcohol, it takes over your mind, body and life. You have no choice once you are in that circle.”

Interviewees described a difficulty in explaining all of the barriers to tier 4 treatment effectiveness since they had successfully moved to abstinence. It was suggested that a more encompassing set of views relating to perceived barriers to treatment would be gained by asking those who relapsed either during treatment programmes or upon planned discharge.

3.5.5 Good Practice

Service users identified areas of good practice within the treatment process and aspects of treatment, which have potential but may require further development and implementation to become effective tools. Interviewees commonly agreed that the educational elements to tier 4 were extremely important and helpful in allowing service users to understand the reasons behind their behaviour. Interviewees also agreed that more preventative measures could be available for young people and that such mechanisms operated as strategic outreach as well as within normal service channels.

Interviewees praised the support branch off and wraparound services and described how instrumental they may be in preventing relapse. It was also suggested that such groups are extremely helpful if relapse occurs and an individual required help and support in ‘getting back to abstinence’. It was expressed that services such as SMART recovery programme are also helpful in determining need and gaps in current service provision. Interviewees also commented that needs assessments should be more regularly and robustly undertaken, with the suggestion that some demographics, such as those from more affluent backgrounds, are particularly underestimated.

“We know it’s difficult, births deaths and marriages do occur and it’s how you deal with it (that counts). These are the problems of being addicted to something for 20 odd years.”

“I would change residential rehabilitation; instead of being fed-down I would have more user influence; there’s not a lot of user influence. I’ve been to meetings where I’m not drinking but I am representing the users. I say I’ll go because users can’t face talking to committee. More user input would help the levels above commissioners to latch on to improvements to the system.”

“Prevention is definitely better than cure; if you catch people early you will save money. Education is a key thing. Now tier 4 programmes are educational, there are some things you are not that bothered about over the three weeks but when I came out I found I was doing things I had learnt in there, even if it was subconsciously.”

Interviewees described mentoring processes as good practice but suggested that mentoring could be extended beyond a particular patient or individual. It was suggested that involving the friends and family of service users would extend the network of support throughout the clients ‘normal’ life. Interviewees expressed that services could perform better in providing for vulnerable and minority cultural groups. It was suggested that services ought to better provide for representatives of BME groups but that gaps in services and recommendations for good practice were not easily ascertained without better uptake by representatives of these groups. It was commonly agreed that such provision should be incorporated into main stream services and not as standalone specialist centres.

“Drugs and alcohol are thought of as separate issues; I was the worst for it, I used to think ‘at least I’m not a druggie’. When I went to meetings, if they had drug meetings in another room, I used to hate them. Since then I’ve realised that they are just the same as us, intelligent people with an addiction to a mind altering substance.”

“Alcohol and drug use has no boundaries, class creed race religion it has no boundaries, if it gets you, it gets you. Asians tend to keep in house don't they, they have drink and drugs problems but they keep it indoors.”

3.5.6 Aftercare & Peer Support

Interviewees discussed aspects of aftercare and the most effective support networks. It was described that upon discharge the individual ‘has a choice again’ and is left with ‘a psychological challenge’. It was suggested that the longer an individual stays abstinent the ‘stronger they become’; expressing that it might take some individuals years to feel comfortable in their abstinence. Interviewees described how contact ought to be extended from tier 4 services, either by the service themselves or by use of a wraparound support facility in order to help combat the psychological barriers to abstinence.

“The next stage is psychological, they have done their job; there could be an extra programme to come to terms with the psychological aspect. It’s about getting people to access real support groups.”

“It’s ok taking a plant out of rotten soil and putting it in the greenhouse to recover in nice surroundings but then if you put it back in the old soil it will start to wither. It’s about sorting the soil out where it’s come from (and) putting community mechanisms like SMART and AA in place.”

Interviewees described the importance of in and out patient group meeting since they effectively bridged the gap between the service and the community. It was described that treatment processes could not be broken down into discrete sections since journeys were individual and complex in nature. It was suggested that ex-service users are generally extremely altruistic and form a very useful support network for current clients of tier 4 services. Service users expressed a strong desire to ‘give something back’; each interviewee described involvement with services or support groups in one form or another, either as mentors or as innovators of new groups.

“I’m now the area coordinator for SMART recovery for the North of England. It is peer led and about mutual aid. I also sit on number of boards and panels, such as the family carers group and a men’s group.”

“I just wonder whether those early drop outs have that moment of inspiration. This is why peer support is so important to have support and encouragement from people who have been there. I’m a firm believer in the empowerment of others. All too often people don’t return to a group like this because they don’t want to be a part of it (the service environment); but we want to come back and tell people to go for it. We want to give something back.”

“It took a long time before I accepted that I couldn’t drink. Now I recognise that it’s my responsibility, my choice; I have a choice. Something I learnt through SMART recovery, I take ownership of me, which was something I never used to be able to do. It was always something or somebody else fault that I was using. I had a collection of negative experiences but ultimately I chose to drink.”

Interviewees described how, upon reaching abstinence, broader changes were manifested in their lives, not just in terms of substance use and related behaviours. For example interviewees described changes in their social network; namely not being able to maintain all of their social groups but spending more time with people in similar positions, recovering from addictions to substances. It was suggested that ex service users are not always happy talking about their problems with health care professional or service workers and that peer led support groups are easier to access. Interviewees described strong support for peer to peer networks and the peer led philosophy, especially when led by service users and openly accessible for both in and out patients.

3.6 Commissioner Interviews

Currently commissioning responsibility for tier 4 alcohol treatments for the majority of areas within Cumbria and Lancashire is within the remit of the North West Specialist Commissioning Team, who commission Greater Manchester West (GMW), an NHS Mental Health Foundation Trust, to provide services, whether NHS or non NHS led. GMW also provides district mental health services in Bolton, Salford, Trafford and substance misuse services in Bolton, Salford, Trafford, Manchester, Wigan & Leigh and Blackburn with Darwen.

Specifically in terms of tier 4 alcohol commissioning, GMW procure specific services on behalf of PCTs within Lancashire. Nationally there is mental health definition set for tier 4 treatment, which has recently changed to exclude inpatient detoxification for alcohol (and drug) units. Historically these were included under the umbrella of the National Definition Set and therefore specialist commissioning, which is controlled by regional frameworks. Interviewees described how recent changes in the National Mental Health Definition Set were responsible for changes in commissioning responsibility, namely a handover from specialist teams back to PCTs and D(A)ATs. It was suggested that the exclusion of tier 4 alcohol (and drug) treatments from the national definition set have dictated this change in process.

Interviewees from Specialist Commissioning Teams, PCTs and D(A)ATs from discrete and disparate areas within Cumbria and Lancashire (Blackpool, Cumbria, North Lancashire and Blackburn with Darwen), discussed tier 4 commissioning processes; ultimately suggesting that variation in policy and process underpins the inconsistencies and barriers to tier 4 alcohol commissioning and service provision in these areas. It was suggested that this review may provide timely insight into good practices and barriers to successful commissioning of tier 4 alcohol services, especially in light of the current economic climate which has led to many PCTs trying to streamline costs and make savings where possible.

3.6.1 Commissioning Responsibility

Commissioners from certain areas described how tier 4 alcohol commissioning was the responsibility of Specialist Commissioning Teams, others described how commissioning in their areas was the responsibility of both D(A)AT and PCT representatives. It was highlighted that in areas overseen by specialist commissioning that, at the time of interviews, the responsibility was in the process of changing hands from specialist commissioners back to the PCTs and D(A)ATs. Interviewees described how such a shift would have a multitude of consequences which were of potential benefit or detriment, depending on stakeholder perspective. Interviewees expressed wide ranging opinions regarding this change.

Specialist commissioners commonly agreed that there were advantages to specialist commissioning and risks associated with the changeover. Advantages described included benefits of overseeing of a collaborative approach; commissioning based on effectiveness and achieving value for money over wide geographical areas. Disadvantages of specialist commissioning outlined by interviewees included the disproportionate allocation of funding, less specialist knowledge of localised

parameters and the loss of a PCT's ability to re-allocate funding to either preventative or wraparound services, such as accommodation and employment services. Most participants agreed that transitional periods must be carefully planned in order not to risk de-stabilising services and risking closures in the short and intermediate term.

Specialist commissioning was historically utilised owing to the high cost low volume nature of tier 4 services and it was suggested that commissioning across wider areas allowed an informed overview of budgets. It was highlighted by PCT representatives that referring to non-proximate services could be a barrier to treatment effectiveness. It was expressed that the Specialist Commissioning Team utilised very few services. One service, it was suggested, accounted for the vast majority of referrals from the specialist team and it was on the basis that the service was able to cater for the most specialist needs. Interviewees identified such needs as; acute mental and physical health problems, such as renal or cardiac problems; poly drug use; pregnancy; and complex offending histories. It was also expressed that specialist services were better able to accommodate such complex needs.

It was described that specialist commissioning had the potential to achieve better value for money; the higher volume of contracts a commissioning body holds, the better price can be negotiated. A number of beds are purchased per year with certain allocation being assigned to each PCT area. The PCT may pay for the number of beds given to them but there is an element of risk share since if one PCT uses more or less beds than another, the cost may be balanced accordingly between areas. PCT representatives suggested that such an arrangement reduced PCT responsibility and would be of more benefit to some areas than others.

Specialist commissioners and PCT representatives generally concurred that commissioners had an incentive not to under-spend. Therefore adjustment between PCTs ought to ensure a degree of efficiency and value for money, especially when balanced over a period of several years, as is the practice among Specialist Commissioning Teams. It was expressed that this policy should make the procurement process more closely aligned with need. While this was presented as a potential disadvantage of localised commissioning, it was stated that there would be strong recommendations to continue a collaborative approach. PCT representatives from some areas argued that without localised knowledge, needs could not be accurately assessed, which would negate the advantage of overarching commissioning.

“As provision for substance use has increased, there is less need for it to be regionally controlled, more of a push for local commissioning of services. (We are) in the process of handing it (commissioning responsibility) back to PCTs. It will be done through contractual arrangements, hopefully still on a collaborative basis because there is value in that.”

Specialist commissioning representatives expressed concern that tier 4 may not be highly prioritised by all PCTs, for example it was suggested that some areas may prefer to invest tier 4 funds in tier 3 services, preventative measures or on wraparound services. It was expressed that there may be a lack of cultural acceptance of tier 4 in some areas owing to the high cost low volume nature of the

service provision. It was suggested that if multiple areas prioritise investment to tier 3 or wraparound services, tier 4 service providers may become destabilised and potentially face closures. While tier 4 services may be high cost low volume, commissioners concurred that tier 4 service provision is undoubtedly an essential aspect of alcohol treatment; an ‘irreplaceable end of the treatment line’.

Interviewees suggested that commissioners from certain PCTs may view investment in highly specialised tier 4 services as a potential source to save funding by reducing the number of beds commissioned. It was described that such services may be rarely used and some areas with relatively lower needs may ‘hope for low numbers’ and refer those individuals to out of patch specialist services. The risk, it was suggested, of saving funding in this way is that services may be unavailable when needed, especially if the level of need is above estimations. A key point highlighted by interviewees is that while tier 4 alcohol services are high cost and low volume, there is no alternative for those that require this nature of treatment. The detriment may be compounded if such individuals have no alternative but to take a hospital bed for indefinite periods.

“Under specialist commissioning contracts, Lancashire PCTs are all combined, leaving us with a certain capacity. We are only allowed a share and we use all of it.”

“PCTs have modernised tier 4 at different times, some have not begun to. Some (PCTs) are saying if costs can be cut, such savings should balance the overspend in PCTs generally. Whether funds go to prevention and well being, we don't know.”

“It becomes part of PCT responsibility, no longer can we say ‘that's out of our remit’ but with the local move, boundaries will be sorted and hopefully a more joined up approach will be employed. Local services can be tailored to better support tier 4 needs.”

Interviewees expressed concerns about destabilising services during the intermediate term of the transitory period. This risk of destabilisation, it was commonly suggested, could be reduced by continuing to utilise a collaborative approach. While a collaborative approach cannot be enforced, interviewees expressed that they thought PCT and D(A)AT leads would have sufficient maturity to work in a coordinated way. It was suggested that services would still be an essential requirement, even if they are only utilised by a very low number of individuals each year. For this reason should the transition destabilise services in given areas, harms would inevitably be incurred for those requiring tier 4 treatment.

Interviewees described how under the current collaborative commissioning arrangement some PCTs would inevitably get less value for money than others, describing a ‘mixed economy’. Interviewees in favour of collaborative commissioning described how such mixed economy could be equilibrated by compromising budgets by maintaining a collaborative overview but allowing PCTs to handle their own sub-pools of funding based around needs-led initiatives. It was suggested by some interviewees that there was a lack of belief in tier 4 services in some areas in terms of demonstrating value for

money. It was expressed that specialist commissioning provided an ‘insurance policy’ across PCT areas which would be subsequently lost with a move towards locally managed commissioning.

Some interviewees expressed that it may be possible to save money on costly tier 4 treatments by investing more in preventative and community based approaches. It was suggested that the transition from specialist teams to local health authorities or local D(A)ATs would be welcomed and encouraged since it would allow greater budgeting flexibility. It was also expressed within this context that owing to the current economic climate PCTs would need to make cuts in investment in order to implement these changes.

Interviewees from specialist commissioning areas agreed that while current responsibility was with specialist commissioning teams, PCTs and D(A)ATs had an unsatisfactory level of communication or involvement with the commissioning process. Most acknowledged that with the proposal for responsibility to hand commissioning responsibility back to PCTs and D(A)ATs, flexibility would be lost but that several advantages may be gained. Representatives of local authorities and local D(A)ATs expressed that the main benefit to more locally based commissioning was the influence of local knowledge. Such specific parameters, it was suggested, could reshape commissioning based more closely on local need, characteristics and geography. Such commissioners, converse to the opinion of specialist commissioning representatives, argued that they were better positioned to improve value for money. Local flexibility, it was suggested, would enable commissioners to develop and work with new service providers, especially in the private sector. It was suggested that many private services were capable of providing high quality services, on parity with NHS led performance, but that such services were underutilised and many referrals were directed out of area. It was described that such inefficiencies could be streamlined with associated risks reduced by utilising spot purchased contracts for the majority and offering block purchased contracts to consistently well performing services.

“(We have) just modernised tier 2 and tier 3 to form a local integrated model of delivery, (this) leaves tier 4 as an anomaly. Drug and alcohol will be fed from the integrated model so (this transition) gives us a massive opportunity to design a locally accessible integrated service model.”

“Does tier 4 have to be around a certain, rehabilitation or inpatient models or can it be an extension to tier 3 with opportunities to receive detoxes and rehabilitation in more community based model? Can it be localised and delivered by a range of providers and can it be a collaboration between NHS and non NHS sector? We need to coordinate so we don't have a fragmented approach with no efficiencies of scale, we also need to coordinate across Lancashire and the North West so contracts don't collapse while we design new models and assess needs and which services can provide for those needs.”

Interviewees from some areas described how shared care may be a nationally led but locally managed mechanism to incorporate expertise from multiple areas of care, channelled into substance misuse commissioning and management. It was suggested the Department of Health led

guidance and recommendations may be utilised to drive standards in each locality. While NHS targets, it was expressed, may be more definitive and clearer across areas, mechanisms of shared care should incorporate independent sector services providing they meet required standards. It was also stated that monitoring of services should also be guided by principles of shared care, with wider governance of monitoring for alcohol (and drug) services. Such recommendations were highlighted in response to reported variation in quality and standards of tier 4 alcohol services.

Interviewees expressed that PCT management of funding would benefit from an overseeing body. Interviewees commonly agreed the only organisation that may be capable and appropriate would be the Strategic Health Authority (SHA). Interviewees also expressed that PCTs would benefit from remaining mindful of which provisions have received what investment and how the investment had been utilised. It was expressed that should such investment not be continued then services may become destabilised, rendering previous investment as wasted. Interviewees suggested such smooth transition relied upon transparent communication, strong cooperation and strategic linkup between specialist commissioning teams and local commissioning bodies.

Interviewees from one PCT, which did not fall under the umbrella of specialist commissioning, described how commissioning responsibility was divided between the PCT and the D(A)AT. Interviewees suggested discussions were ongoing to combine commissioning responsibilities within the D(A)AT, since currently drug service commissioning responsibility was with the D(A)AT and alcohol service commissioning responsibility was with the PCT. This division of responsibilities, it was suggested, caused significant problems, especially when considering individuals with both an alcohol and drugs problem. It was further suggested that the entire commissioning responsibility for alcohol would not be transferred at one time and that the residential rehabilitation budget would be handed to the D(A)AT approximately a year before the inpatient detox budget. It was suggested that in some areas the rehabilitation budget was very difficult to manage owing to unclear needs assessments and inaccurate referral estimates. Interviewees expressed that such disjointed processes were a substantial barrier in attempting to streamline commissioning processes and improving value for money.

Interviewees from a non-specialist commissioning area expressed that historically and as part of normal practice, NHS led services would be exclusively commissioned. Despite such services very often operating at capacity with long waiting lists, more local independent services were not commissioned, despite meeting performance targets. It was suggested that should control of funds be localised and managed cooperatively, such potentially vulnerable but able services may be developed and commissioned where appropriate. It was further suggested that such an arrangement would improve value for money, with service user needs met in the local area, with only exceptional circumstances leading to our of area referrals.

3.6.2 Contracting

Commissioners commonly expressed that with the initiative of World Class Commissioning, commissioning bodies were obliged to move away from procurement on the basis of historical relationships. Interviewees in some areas described how budgeting and assignment of funding was

managed by multiple individuals and commissioned by multiple bodies. For these reasons, it was suggested that commissioning occasionally lacked direction and leadership. It was suggested that collective aims should include equity across and between counties.

Contract procurement may vary between one off flexible spot purchasing which entails buying a number of beds in a one off transaction, or block purchasing which may involve block buying a certain number of beds each month or year. Interviewees described advantages and disadvantages for both processes, which were dependent on the nature of the service users, service stability, service specialisation, service performance levels and historical relationships between services and commissioners.

Interviewees described how contracting often varied between NHS led services and private, independent services; it was commonly suggested that block contracts were more likely to be purchased among NHS led services while spot purchased contracts were more often arranged with non NHS led services. The implication was that NHS led services are, in some cases, more reliable in terms of performance and outcomes and for this reason were rewarded with longer term and more secure contracts. It was suggested that commissioners would account the trade off between factors of local and better value services and more specialist, sometimes out of areas, services. Commissioners indicated that ideally block contracts would be utilised in order to gain stability and trust between commissioners and providers but such block contracting does not allow great flexibility in the number of beds commissioned or service user preferences. Interviewees described that spot purchasing was more labour intensive but ultimately more cost effective since commissioners have more control and flexibility over the quality of service purchased.

Interviewees indicated variation exists between areas in terms of contracting policy, while some commissioners preferred developing long term relationships with particular services; others preferred the flexibility provided by spot purchased contracts. Some interviewees indicated that a combination of each method enabled long term trust and stable development through block contracting but with the flexibility to spot purchase additional beds where necessary and required. The potential to spot purchase, it was suggested, also allowed independent services to establish themselves with commissioners with reduced risk and the potential to procure more beds from services that demonstrate satisfactory outcomes.

Interviewees expressed the importance of needs led contracting and how in some cases block purchased contracts may not accurately meet the level of need. In some cases, it was expressed that the level of need may not meet the number of purchased beds and a given area may lose out for this lack of flexibility. While it was suggested that services may have arrangements where contracts and beds may be balanced out within the year, such balancing could not be carried out on a year to year basis. It was expressed that while spot purchasing allows greater flexibility and in some cases value for money, it requires a higher level of quality management.

“For us it’s all spot purchased, which makes it much more flexible but on the other hand more complex in terms of quality managing, especially when dealing with some private or third sector (voluntary) agencies. We have just had change in overarching service provider; historically we have kept monitoring tabs on individual care workers, now with new contracts (we are) starting to look at spot purchased service level agreements but its early days.”

“We want to move away from spot purchasing, it doesn't give you the same quality assurances as a formerly commissioned block or activity based contracted services. There doesn't need to be massive NHS contract for a handful of users. We don't expect a smaller service to have to respond to a bureaucratic process five times over. More about specification than the contract; is what you are providing what we need? We have to be sure that we are commissioning the service that meets the needs; that only comes from periodically checking specification, either by competitively advertising contracts or reviewing and refining existing ones in order to better meet identified needs.”

It was suggested that the transition of handing responsibility from specialist commissioners back to PCTs and D(A)ATs would reduce the number of block purchased contracts and encourage a combination of block and spot purchasing. Interviewees also identified this as an opportunity to marry up the procurement of inpatient detoxification and residential rehabilitation in areas where such treatments were commissioned by multiple partners.

“We have a good relationship with services in the most part, we can rely on information provided but we don't hear about it all. Certain things may be hidden; it’s a business at end of day and some services are better than others. For example, if staff were down (absent or unavailable) some (services) would say (to us) and others wouldn't. We have a good relationship (with services) superficially but (the) level of trust varies.”

Interviewees from multiple areas concurred that there was generally an incentive not to under-spend and as a result overspending was often incurred, which would in some cases be offset by ‘slippage’ elsewhere. While commissioners could be ‘told off’ for overspending, without a better overview of year on year spending relating to detailed needs assessments, the incentive would always be not to under spend. Interviewees from non-specialist commissioning areas described how funding was closely linked with targets, which were ‘still about treatment and retention’, so while more funding was required for the current treatment pool, the only way to increase funding was by increasing the treatment pool.

3.6.3 Services Commissioned

Commissioners from certain areas described how process mapping was conducted to identify the nature of treatment provision, specialist facilities in services and service suitability in meeting specific client needs. It was suggested that NHS led services may often be better equipped to deal

with specialist needs or complex users, while non NHS led services may be able to cater for 'lower level need'. Interviewees expressed that while broad trends may be observed between NHS and non NHS led services, commissioning should be based on the diversity of need of the service user and the performance of the specific service as derived from robust needs assessments and detailed monitoring information respectively.

The distinction between medically managed and medically supervised services was outlined by multiple interviewees, with most concurring that medical management, which usually entails twenty-four hour medical assistance, is preferable for service users with the most complex and severe physical and mental conditions. It was suggested that some therapy or general practitioner led services may be more appropriate for less complex cases. Some interviewees expressed that in addition to increased specialism among NHS led services, there were additional assurances over quality and governance since such services are managed under NHS model contracts. While non NHS led services may be operating at equivalent standards, owing to the inconsistent nature of appraising performance, such services were often overlooked.

"(We) haven't always commissioned local services in the third sector (voluntary) but would if they can provide medically supervised detox, or (specialist facilities, such as) family units etc. We are trying to engage with those services. If they have mapped out a viable business model to meet a legitimate need, we can reflect formal agreements contractually and if they provide what we want to commission, we will (commission them)."

"We are starting to form relationships with third sector (voluntary) services and open negotiations to say, for example for a particular unit, demonstrate you are seeing people and meeting need and we can talk about your service, your understanding and how we can formerly commission you. We have some activities with third sector (voluntary) services but they are social community based care, the more cutting edge clinical complexity and inpatient detox we usually commission from NHS services."

"We would consider private (services), we have many private services locally and we do use them on an ad-hoc basis. Sometimes we know that people are using them, if referred by a GP for example, but we might not have contract there so it's about us forming relationship and having range of services that meet individual need. Third sector (voluntary) has capability but we don't have assurances if we are not commissioning them to the same standards and expectation as NHS led services."

Interviewees described how service user feedback was not always balanced and had limited uses in determining service performance. The imbalance, it was suggested arose since service users who had the opportunity to feed back had either completed their programme, gained stability within their treatment journey or moved to abstinence. Often information is generated at service user forums, which are attended primarily by those who had completed detoxifications and moved to abstinence. For this reason non-completing clients or those who suffer relapse post discharge were generally not included in such feedback mechanisms. Interviewees expressed that, while they would seldom receive negative feedback from service users, occasionally complaints were received from

professionals about other service providers. However, it was expressed that such complaints were not sufficiently unbiased to warrant follow up action, unless verified from multiple sources.

“Services may go straight to hospital (for referrals) because it’s cheaper to pay for detox in a service that occupy a hospital bed for a night; not much, but cheaper.”

“For non NHS led services, as a rule, the incentive is more financial. NHS led services understands and has NHS targets, which aims to improve quality and effectiveness. Newer ones (private services) use improved effectiveness as selling point but still only to generate business, but we would consider all new services. For example one new service has developed a mother and child unit, with mixed results. We determine need and performance on an individual (service) case basis.”

“Some services have improved clinical governance for business reasons to sell themselves better (there were complaints about some in the past). NHS have their own targets, charities (voluntary) are centred on governance to get business and private (services) just want numbers through the door. We prefer NHS and charity run services but private services are more locally available, so we are starting to use them more.”

Interviewees commonly suggested that service users would not be referred out of area unless the individual had particular issues in a given locality. One notable exception was from within a locality that had not explored the performance of local services, owing to lack of funds and lack of utilisation of robust monitoring information, in this locality the majority of referrals were out of area. The converse was true in other areas, where interviewees described how the majority of referrals were to local, non NHS led services. However, the suggestion was made by such representatives that private or voluntary led services were more likely to be financially rather than performance driven.

3.6.4 Commissioning on Performance

Commissioners agreed that services should be commissioned primarily on performance, however some interviewees expressed why that was not easy to determine in all cases. Interviewees suggested that services do report completion rates in response to set targets for completions. It was expressed that commissioners have estimates of the number of clients referred from tiers 2 and 3, the average duration of stay and the number of successful completions but that there are gaps and accuracy issues in recorded monitoring information.

Interviewees indicated that while consistent performance indicators would highly useful in commissioning tier 4 alcohol treatment, service providers varied not only in terms of quality and performance but also in terms of working practices models, treatment journey planning, therapeutic community emphasis, personalisation and user choice. Such variation makes consistent comparisons difficult for commissioners to conduct. Interviewees indicated that much information on which services are commissioned is anecdotal or informally derived over periods of working with particular services, not on robust and consistent performance indicators. It was expressed that while some

services would offer step plans of varying duration, 12 step being the most common, it was suggested that average treatment times and waiting lists also varied between services.

Interviewees expressed that services are independently assessed by the Care Quality Commission (CQC). In addition to spontaneous checks on services, the CQC also respond to ad-hoc requests from commissioners to check queries relating to specific services. It was suggested that the CQC was extremely useful for identifying and rectifying sub-standard areas of practice such as prescribing medication, facilities or attention to service user needs and well being. It was expressed that more subtle aspects of performance may not be addressed by such independent checks, for example specialist facilities such as single sex rooms or family areas, staff or access to medical expertise, structured daytime activities, data monitoring, attention to evidence based manuals, unplanned discharge policy and service user follow up, all of which may significantly contribute to the success of treatment outcomes.

“The CQC (independent quality assurance) went in and removed all their stars (given for meeting standards) due to sloppy medication regimes, not recording medication etc. The CQC carry out spot checks, they also take an ex-user with them to act as mystery shopper. They (the CQC) carry out check at least once a year, more frequently if concerns arise and will go in on our say so if alarm bells are ringing. It’s a very handy tool.”

Interviewees generally indicated that much of the performance evidence came from individual case studies and not quantifiable data; it was suggested that the reason was that there was no generic template for all services to utilise in reporting of aspects of performance.

“Some services have stubborn habits; they don't fit 12 step plans. Others are easier but we still prefer to spot purchase large numbers of bed nights on short term level agreements.”

“There are various reports written for effectiveness. With World Class Commissioning the whole package should be considered, not just historical relationships. System dynamics modelling can be used to advise commissioning groups, who advise executives and boards, who have the power to revise budgets.”*

*System dynamics modelling is an approach to understanding the complex behaviour of systems, over time, in this case the movements of individuals between tiers of treatment and the wider community. Such complex modelling accounts feedback loops and time delays, which affect the behaviour of the entire system (SDEP, 2009).

3.6.5 Data Monitoring

Most commissioners concurred that data monitoring was the only genuine mechanism to ascertain service performance but that there were shortfalls in standard monitoring mechanisms and the accuracy of data reported. All interviewees were familiar with the NDTMS but mixed views were observed relating to the application of such monitoring information. While some interviewees expressed enthusiasm and offered constructive suggestions to improve the recorded data, others outlined their own alternative monitoring systems. Interviewees also commented that services did not record data in a uniform way or to the same level of quality, which not only convoluted the reporting process but presented a barrier to fairly appraising services based on performance.

“I don't think we've used monitoring information effectively. Now we are starting to but it would help to look at performance indicators. Currently we don't really have that apart from simple output information, such as how many beds, (how many) completions etc. (There are) lots of data outputs but (they are) lacking on outcomes.”

“Care coordination requires better management in terms of monitoring side. Effectively we would like to know what we are getting is what we paid for, a true efficacy measure.”

Interviewees assigned varying levels of importance to monitoring processes and such variation was reflected in expressed commitment to data monitoring. While some interviewees described multiple monitoring and reporting processing, others described how they received very little monitoring information. Interviewees concurred that data monitoring was a key aspect to ascertaining the outcomes and effectiveness of a given service. It was agreed by interviewees however that data monitoring processes needed development and refinement to accurately ascertain indicators of performance. It was also suggested that tier 4 alcohol service monitoring was less comprehensive than tier 4 drug service monitoring.

“We don't use the NDTMS data. Their system feeds all their requirements; we expect a data set which comes through SLAM (alternative monitoring system), which is fed into our system. Any red-flag outliers are questioned through the feedback loop. They (services) submit monthly but they do find it difficult to meet deadlines, partly due to how they record their information; some information we ask for is not recorded electronically, so we have to wait for some aspects of feedback data.”

“There is duplication of information. Use of this information would take a lot of collaboration and link up; it wouldn't happen.”

Interviewees demonstrated varied prioritisation in terms of re-modelling tier 4 processes and improving data monitoring information. While some expressed that improvement in data collection and assimilation would better represent service performance, others described how aspects of tier 4

were difficult to quantify owing to the individualistic nature of tier 4 service provision. For example interviewees described how information, such as how treatment impacts or is received by the individual, the individual's drinking profile upon entry to tier 4 services and the ability of service workers to act as mentors to service users, may all be indicators of performance.

"We collect lots of things like length of time from referral to entry, length of time from provision service, whether reviewed on time etc. We collect how long (people stay) in rehabilitation and try to monitor how long before someone comes back. We are trying to address what people do after planned discharge; do they stay abstinent or come back on system? (There is) no mechanism to follow up planned discharge...we tried but a lot of people have put that behind them. At closure it is bounced off the person but how you feel at exit point may be very different to a few months down the line."

Interviewees also concurred that aftercare was a crucial aspect of tier 4 treatment and the ability to follow up service users upon planned or unplanned discharge would be a particularly useful tool, especially if extended as far as numbers going into employment, although such following up had been previously explored and significant barriers had been encountered. It was suggested by interviewees that information, such as client drinking profiles upon entry to tier 4, would be a useful inclusion to monitoring information, and would be useful in determining treatment effectiveness and aid in refining referral criteria. It was also suggested that the impact on the individual would be a useful indicator of service performance, since tier 4 treatment success can be determined by the mind set of an individual. For this reason one very important aspect of tier 4 treatment may be to assess staff morale as an indicator of a service's ability to mentor and inspire.

"With specialist commissioning, I personally have had fragmented arrangement around any kind of information; of late I have had activity based information from Greater Manchester West about numbers of people from my locality that have been through service, occupied bed nights etc. I have been unclear as to what specialist commissioners get, what should come to us, what they should do to interrogate it, challenge it or measure that it is a service that is delivering good outcomes. I know more about service 'X' from its reputation, from local referrers, from service users and my own impression from visits rather than the data provided from them through specialist commissioning."

Interviewees described how integrated models had been well developed among tiers 2 and 3 of treatment but that such modernisation had not uniformly occurred across tier 4 services. Interviewees suggested that tier 4 was often considered as isolated from the lower tiers of treatment, especially in terms of commissioning processes. It was suggested that such isolation had created inconsistencies between tiers in terms of monitoring quality, accuracy of performance indicators and breadth of information recorded.

It was suggested that tier 4 integrated modelling would be of substantial benefit, from which tiers 2 and 3 could provide a useful framework. It was also suggested that model development of tier 4 ought to use the same integrated approach; ‘we would hope to set the same standards in modelling for any tier’. It was further expressed that monitoring and assessment of tier 4 service performance was more difficult than in other tiers because monitoring information relates to the period of inpatient detoxification and did not account post-treatment time frame, during which relapses may occur.

Commissioners suggested that variation in monitoring mechanisms and priorities were reflected in the reporting of information. It was also indicated that reports generated from monitoring information were not as widely distributed or utilised as they may be. While some commissioners indicated that they did not receive sufficient information, others described receiving information from a wide range of sources and from varied templates. It was suggested by most interviewees that processes surrounding monitoring and reporting required streamlining and coordinating in an effort to create a high and consistent standard among services and commissioners. Interviewees concluded that effective commissioning is reliant upon effective performance appraisals.

“If you can’t commission the whole care-pathway it becomes difficult to monitor it all.”

“They do generate a lot of reports; I get 16 different reports at end of every quarter, which are all very similar. Collation is the key but who takes responsibility? I would be happy to if relevant parties could agree a generic template.”

3.6.6 Service Specialism

Commissioners described inconsistencies among referral pathways; it was suggested that a substantial percentage of referral pathways were based on historical relationships and that service specialism or performance did not in all cases closely relate to client need. It was also described that commissioners were not always clear about what particular services provided in terms of specialist facilities, expertise or management.

Opinion was divided among interviewees as to whether each service ought to be capable of dealing with the most complex cases through medical management or supervision or whether the most complex cases, such as section one offenders, should have specific services to meet specific needs. The most commonly agreed suggestion was that non NHS led services may be utilised if possible and where appropriate but for more complex cases that require a higher level of expertise or medical management, NHS led services may be more suitable.

Interviewees described how certain services had gained reputations as being able to deal with the most complex cases of dual diagnosis, poly-drug use or service users with complex offending histories. In some cases such services were described as being provided by specialist trusts which

also provided forensic mental health services. It was indicated that such services were ‘provided by people who understand the challenges of dealing with the most complex needs’.

“What about when people aren’t at that threshold at top of pyramid and don’t need the sophisticated intervention with infrastructure and speciality back up and support, not everyone is supported by tier 3 but don’t need that top level provided by the NHS. (There are) lots of voluntary organisations that also support those with offending history, dual diagnosis and poly-drug problems.”

Interviewees described that despite service expertise or specialism to accept the most complex clients, certain service users, such as section one offenders or arsonists, would face difficulties being accepted into any tier 4 service. It was further suggested by some interviewees that very few services would accept clients who were currently taking anti-psychotic medication. It was heavily emphasised by most interviewees that referrals and acceptability was often judged on a case by case basis and if referrers or service users could demonstrate relative stability then often they would often be accepted. It was described that such cases may require continued support from local health teams and that some service providers may charge an enhanced rate for service provision for this type of client.

Interviewees discussed other specific groups such as street sex workers, suggesting that often substance use among such populations was accompanied by a lifestyle of working the streets and the drive to earn cash. It was expressed that often representatives of such groups may discontinue treatment prematurely because they wanted to make money for themselves. Interviewees discussed the feasibility of financially incentivising such individuals to complete their detoxification or rehabilitation course.

Interviewees suggested that representatives of BME groups may have needs which are not adequately provided for in tier 4 alcohol services but that disproportional representation was not solely an issue of inadequately meeting needs. Interviewees generally concurred that such needs should be met with expertise within mainstream services. It was indicated by some interviewees that there may be an element of mistrust among such client groups, especially in terms of information recorded upon entry to services.

It was suggested by some interviewees that representatives of BME groups may be less likely to attend initial appointments and that cultural differences more profoundly affected uptake into treatment than differences in consumption or behaviour. Interviewees expressed improvements in outreach and service processes were needed in order to reduce perceptions of stigmatisation, which often came from families and friends of alcohol or drug users from within BME communities.

“Is there a barrier for BME groups in tier 4? Yes absolutely, they are underrepresented in treatment. We need to look at how we deliver treatment to those groups; clearly what we are doing now is not working. Tier 4 could be one way of attracting people from those communities into treatment; what we have learned is that for BME groups it’s not about maintenance; it’s about coming off substances. We know we are not attracting people from those communities. Prescribing may not be appropriate for people from that cohort because there is a fear of stigmatisation. I wonder whether tier 4 could be made more accessible because it is about abstinence.”

3.6.7 National Policy & Referral Criteria

Interviewees described how national policy filtered down into working practice. It was widely suggested that alcohol was considerably behind drugs in terms of a nationally defined service practices model. It was indicated that considerably more work was needed in understanding alcohol and its effects on individuals and wider society. It was expressed by some interviewees that in the last two or three years considerable improvements in nationally defined referral criteria had been made and that such policy was increasingly driving alcohol service implementation. Some interviewees however, expressed concern that there was very little national policy to guide alcohol budgeting and commissioning.

It was suggested that service providers in the most part were enthusiastic and efficient at picking up national policy developments or changes. However, it was indicated that nationally defined parameters were difficult to derive, since tier 4 provision, while representing a specific aspect of treatment, was appropriate for a wide and diverse range of individuals. It was suggested that alcohol commissioning would benefit from being married up with drug commissioning as opposed to being considered as separate processes.

“There is more weighting for drugs probably because we’ve had national drug strategy for drugs and DATs have been in place for ten years, we only added the (A) recently. The NTA is still not responsible for alcohol; it’s like (with alcohol) we are where we were for drugs ten years ago. Budgets are limited; we definitely need more funding for alcohol and better needs assessments and analysis.”

Interviewees concurred that national objectives should be adapted and put in a local context by accounting local parameters and available funding streams. Interviewees representing D(A)ATs from some areas described how local alcohol strategies had been derived based on national alcohol strategies but that funding to implement such strategies had not been forthcoming. It was suggested that such national definitions and guidance were not useful since there was no accompanying funding to implement more efficient working frameworks. Interviewees from certain areas described how alternate strategies had been derived which required little to no funding and were primarily focussed on preventative measures.

Interviewees described how the outcomes of implementation of policy for drug misuse were easier to quantify than with alcohol. It was suggested by one interviewee that if the proportional population of drug misusing offenders was reduced then a strategy would be seen as effective but in the case of alcohol use, similar reductions in related offending may not indicate a reduction in consumption. It was further suggested that increasingly people were drinking in the home and spending less time in urban centres.

“National policy in all areas, including D(A)ATs, guides us in terms of overarching guidance but ultimately within this area commissioning has to be locally driven according to local need. In this Local Authority, services can be diluted, especially if you have one large provider offering services to one big community. Our service users are very particular, local parameters are very important.”

National policy, it was suggested was most relevant in shaping and refining referral criteria. Interviewees generally agreed that work to develop and refine referral criteria for tier 4 alcohol services would be of substantial benefit but that the referral process would always be undertaken on a case by case basis. Owing to the individualistic nature of service user profiles and services themselves, interviewees expressed it would be very difficult to create robust and consistent frameworks. Interviewees also described how, in some cases, if a client asked for tier 4 treatment they would receive it even if there was a more appropriate treatment available.

Interviewees described how many of the inconsistencies and confusion surrounding referral sources arose from diversity of job roles among referral sources. Some interviewees described how detox nurses should be responsible for tier 4 gate-keeping, others described how GPs should be chiefly responsible while others expressed that referral sources ought to be controlled by the D(A)AT. The variation depended chiefly on the geographical area but also on the relationship between tier 4 services, referral sources, tier 3 services and commissioners. In some cases the responsibility to commission and refer would be different for inpatient detoxification and residential rehabilitation, even if both were carried out within the same service. Interviewees recommended better link-up between rehabilitation and detoxification in these cases. It was suggested that referral sources may not be able to discern the subtleties of appropriateness since ultimately it may not be determined by specific criteria but by an individual’s outlook, attitude or stability.

“There should be more robust criteria for workers who make referrals. It differs with different teams; usually nurses or social workers who refer to tier 4 do assessments and sometimes clients bounce back, either because the client is ‘low level’ and treatment is too intense, or what is expected to be done at tier 3 has not been done. Tier 4 is a last resort; you don't want to refer someone when community detox is possible and appropriate.”

It was suggested that national policy could only be used as a generic guideline, since each tier 4 unit used service-specific inclusion criteria. While some NHS led services would accept most referrals,

except for extremely unstable offenders and individuals with extreme poor health, others services may refuse entry to types of offenders, those with mental health issues, those with polydrug use, those of a certain sex or family circumstance, young people or emotionally vulnerable clients. It was ultimately suggested that unless standard working practices could be developed for tier 4 services, consistency among referral sources would be a difficult objective to achieve.

“Some time ago social workers weren’t clear about their role, they didn't appreciate it was for them to carry out community care assessments, not clinical staff because it comes from community care budgets. It’s about people meeting eligibility criteria, everybody was doing community care assessments; CARAT team workers, probation officers, the quality was pathetic and nobody was recording it on a business information system; directors had no idea what the substance use budget was doing because people were not recording it. Nobody could calculate how many people were accessing tier 4 services because of paper trails all over the place. Also, managers who were approving placements were also approving nursing and residential (tier 4) placements for older people, packages of care for people with physical disabilities, so tier 4 alcohol placements were approved by whether they got on the pile or not, not by any rigorous, robust criteria or knowledge. When all residential rehabilitation referrals would be done by one social worker (about 3.5/4 years ago) it dramatically clarified the process. Residential rehabilitation users grew by 369 in one year (in this area), which was about ten times what it was.”

3.6.8 Service User Feedback

Interviewees commonly agreed that service user feedback was extremely important and that tier 4 service commissioning would benefit from the initiation and development of service user forums; while feedback mechanisms were in place, the emphasis and utilisation of generated information varied across areas. While some commissioners viewed service user feedback as a useful qualitative addition to more robust performance indicators, other interviewees described how service user feedback was critical to the development of integrated treatment pathways. Interviewees from certain areas described how there were very few channels or mechanisms for service user feedback. It was indicated by interviewees from such areas that outcomes from tier 4 were analysed only in the context of returns to tier 3. It was suggested that community mechanisms would be of substantial benefit in creating a more complete picture of treatment outcomes.

“There is a definite requirement for tiers to connect with each other; each tier could better estimate how many (individuals) will arrive and exit. We need to get to that stage, we have modernised tier 3 but without integrating tier 4.”

“We have a service user network, with committee meetings and regular dialogue. The network is a bit up and down, they are concentrating on bringing themselves to a standard where they have good working practices. We are not yet able to maximise the use of their feedback, that's the next step. In time (this information) will link in with alcohol (services) commissioning.”

“We should be using Treatment Outcome Profiles (TOPs), through treatment journey. In reality, not many places are fully compliant with TOPs. It's all about integrated pathways, keeping communication open with users who leave in unplanned way, who picks them up?”

Interviewees suggested that, similar to data monitoring processes, service user feedback for alcohol services were not as developed or utilised as equivalent mechanisms for drug services. Multiple interviewees indicated that steps were being taken to address this disparity. Mostly these steps involved recruitment of specific roles such as ‘service user involvement officers’.

Interviewees expressed that a proportion of valuable service user feedback is lost to unplanned discharges. Interviewees suggested that feedback would be more likely to represent more positive aspects of an individual’s treatment journey since the ‘lost demographic’ would be mostly comprised of those with unsatisfactory outcomes, and therefore those more likely to have encountered barriers within the treatment process.

“We can follow up after 6 months if (a user is) still in care but (there is) no process to do it; we need a mechanism. Without it, it is difficult to determine treatment effectiveness. We need to see where they are 6 or 12 months later. We could have successful completion from one treatment and referred on but successful completion doesn't mean you are cured. We also need a mechanism to monitor unplanned discharges.”

“Nobody wants a nosy social worker, checking up. Some ex-users are proud of being clean and keep contact anyway; you don't want to be too intrusive.”

“At closure it (feedback) is bounced off the person but how you feel at exit point may be very different to a few months down the line.”

“We have the Lancashire service user forum which is standalone from providers. We had members centrally involved in the design of tiers 2 and 3, through consultation and engagement. Users were instrumental and their help assisted with running public consultation and getting engagement from providers, GPs, pharmacists and job centres. Service users were integral to the process of selecting new providers.”

3.6.9 Personalisation, Modulation & Community Care

Interviewees widely acknowledged that tier 4 services are becoming more personalised in line with widespread recognition that tailoring services to the individual may substantially improve outcomes and treatment success. It was suggested that not all aspects of tier 4 treatment were relevant for all services users and that by breaking treatment aspects down, clients would be able to partake in the modules most relevant to them. For example, violent offenders may have an emphasis on anger management; young people may have an emphasis on educational elements; young families or parents may place emphasis on parenting or life skills such as cooking; and those who have relative stability in the community could place emphasis on career development and employment skills.

“(You) could argue that everyone should be given a choice but the truth is it comes down to how much money is in the budget and how many places can be commissioned. We need to keep quality there, for those who need that type of service and we need to try to provide similar services in a community setting, which is much more economical.”

“We have prevalent use in affluent areas where alcohol problems persist. (It is) different to Manchester or Liverpool where model of carer that GMW provides is co-terminus with population, we might need something quite different. We have people among disparate communities in North Lancashire who don't want an institutional model of service provision.”

Interviewees suggested it would be the role of a social worker or care worker to identify if an individual is equipped to make their own choices, before breaking down aspects of tier 4 interventions. It was indicated that such personalisation would not be applicable in all cases, if for example an individual was suffering from poor mental or physical health. Interviewees described that how a pilot project was in place in one area where self directed support was achieved using a menu style choice system for individuals. While such treatment ‘menus’ have not yet been reviewed, it was suggested that the increasing responsibility of PCTs could serve to develop innovative models or service provision, including individualisation of services where possible and appropriate.

“We are more inclined to use services which give clients more control. Can you incentivise services to improve these aspects? At the moment we need to ascertain if it is better for individual to have more choice because we don't know. I think it will be; someone who has been out of control to have that feeling of choice; (then) their treatment will be of benefit, as long as providers are on board.”

Interviewees emphasised that without improved monitoring processes, the effectiveness of individualisation would be difficult to determine. It was suggested that monitoring processes require development and adaptation to include and link between treatment duration (including module specification), follow up (including unplanned discharges), as well as hospital admissions and entry to other tiers of service. It was further suggested that monitoring could eventually help in guiding an

individual through the treatment journey since data may indicate which modules were more or less appropriate for particular clients of given character profiles. Interviewees from certain areas expressed that personalisation and modernisation were more applicable in places where tier 4 service provisions were well established with stable funding streams. It was suggested that personalisation would naturally follow services that have been modernised, are meeting needs and are demonstrating a high level of performance.

“Models of enhanced community detoxification are in very early days, we need both (forms of detox) but getting a balance depends on accurate monitoring information coming back.”

“It’s down to the skill of social worker to marry up the right client to the right service...this did not happen before when anyone could make referrals; now it’s about preparation and visits to rehabilitation units to make sure it’s the right service for them. Now the user gets quite a lot of say in the service they access.”

While the majority of interviewees agreed that appropriate referrals are mostly comprised of dependent drinkers, whose treatment outcomes would be likely to improve if carried out in a tier 4 setting, some interviewees expressed that they believed a percentage of referrals could be successfully detoxed in a community setting. Other interviewees believed that the residential element to tier 4 treatments was essential for dependent alcohol users and that such individuals could not be detoxed or rehabilitated in community settings, since the increased likelihood of relapsing could jeopardise completion rates.

“The community detox team has been expanded through a new model. We are also thinking about routes into rehabilitation; if appropriate we have preparatory groups which carry out group work and psycho-social interventions. We make potential inpatients (tier 4 clients) aware of facilities, the type of clients treated, the facilities, all with the residential (tier 4) coordinator. We build rapport with that person, at the end some say I don't need it, the community might be fine for me but the process enhances choice. Skills of key worker are essential in determining way forward for client.”

“In terms of personalising and modularising tier 4 we are definitely behind other areas. The North East and our area of the North West are behind in awareness about drug use, user perception and treatment provision. The reasons? Geography limits things; Cumbria is a big area so hard to get good catchment. It is easier to congregate services / users within smaller more concentrated areas. It’s not just about control or availability of funding.”

Interviewees agreed that aftercare and wraparound services were often key determinants of treatment success; it was suggested that service users exiting tier 4 were immediately vulnerable upon discharge. Interviewees made comment that, those completing detoxes and going back to their ‘old lives’ within their communities, faced a very difficult challenge. It was expressed that certain

mechanisms and process policies were in place to minimise the chance of relapse upon returning to local communities. One such policy process was the action of social workers and carers who were recommended the maintenance of regular contact with service users from the point of exit.

Interviewees suggested that in the vast majority of cases, services have specified exit strategies and discharge plans, such plans, it was described were always put in place prior to admission. It was expressed that tier 4 interventions required better link up with community based wraparound services such as substance misuse support, accommodation services and employment or voluntary work organisations. Interviewees from some areas highlighted examples of strong link up, whereby certain tier 4 services would feed into relevant wraparound services, which addressed specific needs such as health services, abstinence support and crime prevention, in addition to more relaxed groups, such as life skills, cooking and communication. Interviewees claimed that ‘service gaps at the softer end’, in community settings, despite potentially playing a key role in determining treatment effectiveness, were poorly invested in since outcomes were difficult to monitor and demonstrate.

“It is ensured that anyone in detox has a plan for exit. Visits (from care workers) are allowed a day or two before they (the service users) come out to assess plans. If detox to rehabilitation, they go the same day i.e. no waiting for 24hrs. If they are going back to the community, it is ensured they have a place in aftercare and with wraparound services. Employment and housing services work with tier 3 structured day care and aftercare, but link up could be improved.”

“Aftercare and wraparound services are very important; they can prevent lapse or relapse. We have started to put new money towards developing recovery coaches, (whose) purpose is to work with wraparound services. Prescribed services are that busy, that individuals can be forgotten. We recognised this as an Achilles heel for prescribed services, there has to be management element to it; the new investment was to improve this quality. The D(A)AT played key role in developing more collaborative approaches. (For example) psycho-social services working hand in hand with prescribed services, it is still in development but wraparound has been considered as really important.”

3.6.10 Perceptions of Tier 4

Interviewees across areas concurred that rigorous needs assessments were not always carried out and would be very likely to improve the efficiency of tier 4 alcohol service commissioning. It was suggested that service provision was not closely correlated to accurate needs assessments but that without modernisation and integration of tier 4 alcohol treatments in line with other tiers of treatment, accurate needs assessments were difficult to implement. It was generally agreed that tier 4 provisions fell short of current need in many areas and that, for those who needed such interventions, there were no alternative options.

Interviewees differed in their perceptions on the effects of investment at different stages of the care pathway. While some interviewees described how investment in tier 3 may lead to better uptake and higher flow into tier 4, others described how increasing investment in tier 3 may reduce the flow

into tier 4. As suggested by some interviewees, there is a need for dynamics modelling to account as many variables as possible, including service user profiling, service characteristics, performance, capacity and waiting times, in order to better predict optimal investment.

“If we improve in tier 3 we would see less numbers accessing tier 4. People should be supported as early as possible in their substance use problems and proactively supported in the community, which can get them back to housing occupation and employment etc. On those principles there should be less people flowing into tier 4, less who need the intensity of tier 4 treatments. We need to know what the capacity of tier 4 is and what aspect of tier 4 we should be commissioning. We need a more definitive model for tier 4, should detox be separate from rehabilitation or can we roll the models together?”

“There is a swings and roundabout effect; investment in tier 3 may lead to more people accessing tier 4 but they would be more appropriate. There is an unequal provision of tier 3 across the North West, with alternate criteria depending on how many they need (according to targets) to send to tier 4. Some get knocked back but they might take people on inappropriately because they (the individual) would be better off than if knocked back. However, this uses a bed that someone who really needs it can't have.”

“Would investment in tier 3 services reduce or increase the burden on tier 4? We do need an adjustment to investments. We need a needs assessment. Tier 4 is not accessible for everyone. For example for some women or families it's a very difficult option; there are services of different nature, we need a mixed economy, we need to be able to respond to individual need at a population level. Our problem is managing that in terms of commissioning.”

“Where is the emphasis of investment? We are in the process of modernising tier 3 (it is) very draconian. We need to individualise and look at each tier holistically. It may inhibit the need for tier 4 if tier 3 improves. Assertive outreach can accomplish things in the community for dependent drinkers, especially for those you will not get into treatment. Outreach services almost be-friends these clients; then when you get them to a centre, suddenly it's not so bad; but they need people (in outreach) because they are isolated.”

Interviewees agreed that the problem was not simply an issue of investment, since investment ought to be considered in terms of capacity and quality, not one or the other. While waiting lists were a key issue for address, if services were operating at capacities, or if investment was used to increase capacity alone, treatment effectiveness may be adversely affected. However, owing to the nature of treatment and the importance of the service user's frame of mind, if clients were made to wait to gain access to a bed they may lose their impetus and drive to move to abstinence. Dynamics modelling may help to indicate optimality amidst this trade off.

Interviewees generally agreed that despite the high cost nature of tier 4, without such provision and incurred costs, those who required such intensity of treatment would undoubtedly cost more in

terms of health and offending burdens. It was suggested that there was an excess of need when compared to tier 4 provisions and that such disparity was wider among alcohol services when compared to drugs services. Multiple interviewees described a lack of confidence in some services, which accounted for the extremely long waiting lists for other more reputable services.

“Effectiveness saves on overall health burden. There will always be a need for tier 4 services because it follows on from other services; when alcohol use gets to certain stage there will be need for tier 4...however that does not detach from the money we need to invest in prevention and other community projects such as education, social inclusion and employment.”

“Would it be possible to streamline tier 4 across larger geographical areas, if funding is reduced by some PCTs? Can anyone oversee the PCTs and stop them trimming back? I am trying, I am imploring PCTs not to. We strongly recommend that they continue to commission collaboratively. There is dissent among some of them; we have battle on hands but I can only advise. SHA could enforce. Some PCTs are very happy to continue collaboratively, especially on the drug side; alcohol is the problem.”

“I believe in tier 4, it is high cost low volume but, when done well, it decreases the overall burden. If we provide high impact high intensity access then we need high intensity exit. We have invested in a local drug treatment system and have restructured and remodelled that system so it’s more integrated; tier 4 is a vital part of the treatment process.”

Interviewees varied in their perceptions in terms of categorising service users, while some described discrete groups of drinkers each with certain characteristics, others described the need for a more holistic or individual approach, since discrete boundaries were not easily identifiable. Some interviewees argued that all services should have the ability to accommodate all types of users while others described how certain users would be more appropriate for specific services. However, it was suggested that such appropriation would be difficult to coordinate, especially if, in an effort to economically streamline, such coordination was over a wide geographical area. While such investment to streamline would be welcomed and could improve efficiency in the longer term, it was suggested that as long as commissioning was carried out on a historical basis, overarching coordination would be very difficult.

“I see a different ball game among drinkers; harmful binge drinkers compared to high end dependent drinkers. Binge drinkers if they are not careful may become chronic drinkers of the future but I don’t think it necessarily follows on. Because of differences between those who drink socially and those who depend on it, appropriate treatment is routed in different tiers, but the distinctions are not always clear.”

Multiple interviewees described how part of the challenge of streamlining, improving effectiveness and improving the value of tier 4 alcohol services was changing culture and perceptions of such interventions. Part of this challenge, it was described, was taking cheap but effective measures to improve perceptions and understanding of alcohol related harms and treatment methods among relevant stakeholders and the general public.

“People need to understand the importance of investing in alcohol to prevent problematic behaviour downstream. Systems we work within are more comfortable reacting than preventing. Changing culture is not a quick process, not only for the general public to change their idea of drinking but to get organisations to change their understanding of prevention and reaction.”

4.0 Conclusions

The overriding conclusion of pooled data is that improvements in link-up and collaboration is required between:

- PCTs, D(A)ATs and specialist commissioners
- Commissioners and service providers
- Services and service users
- Service users and commissioners

In terms of improving treatment outcomes, while undoubtedly commissioning based on performance, robust performance indicators, detailed data monitoring and strong service user feedback are crucial to improving outcomes, the ability of care staff to inspire and encourage is of equal importance in achieving treatment success. Owing to the individualistic nature of problems arising from alcohol dependency, staff morale and therefore dynamism and leadership are cited by service users as key aspects of good practice.

4.1 NDTMS & Pro-Forma Data

- To date there has not been rigorous, in depth needs assessments, married up to accurate monitoring information about numbers of clients accessing services.
- Not all services record and report information to NDTMS equally in terms of regularity, accuracy and quality.
- Service pro-formas verified NDTMS data relating to age and ethnicity of individuals accessing tier 4 treatment.
- NDTMS information was contradictory to evidence in the literature regarding the uptake into services by gender; 33.4% of tier 4 alcohol service users were reported to be female in 2008/9.
- NDTMS data and pro-forma data were contradictory to ANARP (2004) data in terms of the number of non-attending referrals and the percentage of self referrals.
- The vast majority of clients (76.3%) did not state a secondary substance, 45.2% of those that did, stated cannabis.
- Pro-forma information presented contradictory data with regards to most common referral sources; while NDTMS data indicated Statutory Drug Services and Other sources made up approximately two thirds of tier 4 referrals, services described Community Drug Teams and Social Services to comprise a similar proportion.
- Service pro-forma data demonstrates there are 22.8% non-attending clients, which indicates referral process may not be operating optimally or as efficiently as may be possible.
- NDTMS data demonstrates a percentage of 21.9% non-completing clients, which is a substantial proportion and may have the potential to undermine the cost effectiveness and efficiency of tier 4 treatment.
- Fees vary across services but not by nature or performance of the service.
- The proportion of clinical staff of total staff vary between services of different constitutions, with statutory service staff comprising 78.1% clinical staff compared to 14.0% among voluntary services.

- Services vary in terms of client screening methods, accepted referral sources and available structured activities.
- Service user proportions are dominated by White clients, suggesting there may be barriers to treatment for representatives of Black and Minority Ethnic groups.

4.2 Service Manager Interviews

- Service managers suggested that different PCTs have different service level agreements and that such agreements were partly historical and partly in the process of ongoing development.
- Service managers suggested that for some areas, it was cheaper to send clients out of area than to localised service providers.
- It was suggested by NHS led representatives that there were considerable shortfalls in tier 4 service provision.
- It was suggested by non NHS led representatives that they were often operating under capacity, in some cases by as much as 40%.
- Service managers suggested that the proposed removal of a specialist component of commissioning was generally met with approval by service managers. Rather than gaining benefits from commissioning specialists, service managers argued that the change would 'remove a middle layer' and potentially improve the accuracy of commissioning based on local need.
- Service managers suggested that monitoring was not undertaken with a long term view and that often commissioning was 'cherry picked'.
- Service managers generally drew a distinction between medical management and medical supervision, with suggestion that NHS led services were more likely to be medically managed.
- Service managers suggested that private services were less likely to accept a range of client referrals when compared to NHS led services.
- Service managers expressed concerns that some services may not be fit for purpose but that the improving facilities with additional funding or translocation of services were not realistic possibilities.
- Service managers discussed the role of tier 4 services within the care pathway, with most service managers agreeing that service effectiveness would be improved with enhanced links with both tier 3, aftercare and community services.
- Service managers expressed that services could improve policy and practice regarding the transition from tier 4 services back to the community.
- Service managers suggested that not every service, depending on facilities, capacity, staff specialism and level of medical supervision or management, would necessarily be capable of accepting a broad spectrum of clients.
- Service managers agreed that acceptability of clients is often determined on a case by case basis.
- Service managers suggested that monitoring was not consistent between services, in terms of recording templates and utilisation of the information.

- Service managers expressed varying levels of enthusiasm and belief in data monitoring processes; some service managers suggested that reporting and feedback information was seldom used constructively.
- Service managers discussed the importance of developing treatment and care pathways by enhancing and utilising an evidence base; it was suggested that detoxification programmes had been developed in line with the medical evidence base.
- Service managers concurred that, in most cases, community based treatments were inappropriate for dependent and chronic alcohol users, since detoxification is abstinence based and difficult to monitor and achieve in a community based setting.
- Service managers indicated that modernisation of tier 4 was a pre-requisite for individualisation of treatment. It was further suggested that breakdown menus and a choice of modules could be considered but only once the cost effectiveness and performance of the treatment had been demonstrated.
- It was suggested that monitoring processes require development and adaptation to include information relating to treatment duration (including module specification), follow up (including unplanned discharges), as well as hospital admissions and entry to other tiers of service provision.

4.3 Service User Interviews

- Service users suggested that alcohol affects individuals in different ways, especially when coupled with physical or mental health problems or poly-drug use.
- Service users expressed that often adverse circumstances led directly or indirectly to alcohol use.
- Service users described unsuccessful attempts to self treat, either by cutting down their drinking or in one case by using other substances to address the symptoms of their chronic drinking.
- Service users agreed that the overriding emotions or feelings of dependent drinking were loneliness and worthlessness.
- While some service users described relapsing and receiving multiple detoxifications, other individuals successfully moved to abstinence after their first period in tier 4 treatment. Interviewees concurred that their 'mind set' and alcohol use was never the same after their first inpatient detoxification.
- Service users commonly described a desire to help others in similar positions upon reaching abstinence which, it was suggested, could have long term implications for the cost effectiveness of this type of treatment.
- Service users described wraparound and support services as crucial to the treatment journey.
- Service users indicated a strong influence and key determinant of treatment effectiveness was the state of mind, outlook and attitude of a given client.
- Service users described the importance of having a mentor, an inspirational figure to guide them and instil belief that abstinence could be achieved.
- Service users suggested that addictions may be switched or transferred; which emphasises the importance of a 'poly-approach' to tier 4 treatment.

- Service users described excessively long waiting lists for some services in some areas.
- Service users generally described tier 4 alcohol treatment to be a ‘completely essential’ service. It was suggested that for a large number of dependent drinkers, there was no suitable alternative.
- Service users described feeling stigmatised by the general public, even after gaining stable abstinence.
- Service users agreed that the educational elements to tier 4 were extremely important, as were involving family and friends in the educative process.
- Service users agreed that provision for vulnerable groups should be incorporated into main stream services and not operate as specialist centres.
- Service users described how upon discharge the individual is left with a psychological challenge, the difficulty of which was often underestimated.
- Service users indicated that service user feedback does not always represent the full spectrum of client views; it was suggested that perceptions of non-completing clients were seldom recorded and utilised.
- Service users described the importance of inpatient and outpatient group meetings and emphasised the potential worth of peer support networks.

4.4 Commissioner Interviews

- Commissioners described how tier 4 treatment commissioning processes varied between areas.
- Specialist commissioners commonly agreed that there were advantages to specialist commissioning and risks associated with the changeover to more localised commissioning. Advantages described included; benefits of overseeing a collaborative approach; commissioning based on effectiveness; and achieving value for money over wide geographical areas. Disadvantages of specialist commissioning outlined by interviewees included; the disproportionate allocation of funding; less specialist knowledge of localised parameters; and the loss of a given PCT’s ability to re-allocate funding to either preventative or wraparound services, such as accommodation and employment services.
- Commissioners concurred that transitional periods must be carefully planned in order not to risk the de-stabilisation and closure of services in the short and intermediate term.
- Specialist commissioning representatives expressed concern that the procurement of tier 4 alcohol services may not be highly prioritised by all PCTs; interviewees suggested that such services may not represent good value for money.
- Some commissioners expressed that it may be beneficial to save money on costly tier 4 treatments by investing more in preventative and community based approaches.
- Interviewees suggested that locally managed commissioning would enable greater flexibility within a given area but that PCT management of funding would benefit from an overseeing body.
- Commissioners concurred that shared care would benefit from nationally leadership with local management.

- Commissioners suggested that without coordination and linked up commissioning, accurate appraisals of need and the relative weighting of alcohol and drug services was very difficult to determine.
- Commissioners described how contracting often varied between NHS led services and independent services. It was generally suggested that block contracts were more likely to be purchased among NHS led services while spot purchasing was more commonly utilised among non NHS led services.
- Commissioners suggested there was a trade off for commissioners between local and better value for money services and more specialist services, which may be located out of area. It was suggested that some commissioners preferred procuring based on long term relationships with particular services, rather than developing relatively newer services.
- Commissioners from multiple areas concurred that there was generally an incentive not to under-spend and as a result, overspending was often incurred.
- Commissioners agreed that services should be commissioned primarily on performance, however some interviewees expressed that performance was not always easy to determine.
- Commissioners concurred that data monitoring was the only genuine mechanism to ascertain service performance but that there were shortfalls and problems in standard monitoring mechanisms and processes.
- Commissioners described variation in the perceived importance of monitoring information, how information is reported inconsistently by different services and how information may not be widely applied.
- Commissioners generally indicated that much of the performance evidence came from individual case studies and not quantifiable data.
- Commissioners expressed variation in their perceptions of NHS and non NHS led services; some interviewees described commissioning based on performance, when possible determine, while others described having 'more faith' in NHS led services.
- Commissioners described how certain services had gained reputations as being able to deal with the most complex cases and that it was difficult for other, often non NHS led, services to 'penetrate the market'.
- The distinction between medically managed and medically supervised services was outlined by multiple commissioners, with most concurring that medical management, which usually entails twenty-four hour medical assistance, is preferable for the most complex clients.
- Commissioners commonly agreed that service user feedback was extremely important and tier 4 service commissioning would benefit from the initiation or development of service user forums.
- Commissioners suggested that, similar to data monitoring processes, service user feedback for alcohol services were not as developed or utilised as equivalent mechanisms for drug services.
- Commissioners described how service user feedback was imbalanced, since service users who had the opportunity to feed back had usually completed treatment or gained stability within a given programme.

- Commissioners demonstrated varied prioritisation in terms of modernising and re-modelling of tier 4 processes.
- Commissioners described how integrated models had been well developed among lower tiers of treatment but that such modernisation had not uniformly occurred across tier 4 services.
- Commissioners described inconsistencies among referral pathways; it was suggested that a many were based on historical relationships and that service specialism or performance did not closely relate to client need in all cases.
- Commissioners described how many of the inconsistencies surrounding referrals arose from diversity of job roles among referral sources.
- Commissioners suggested that alcohol was considerably behind drugs in terms of a nationally defined service models.
- Commissioners suggested that providers in the most part were enthusiastic and efficient at picking up national policy changes or developments.
- Commissioners in some areas suggested that national policy ought to be used as a generic guideline but be adaptive to local parameters.
- Commissioners widely acknowledged that tier 4 services were becoming more personalised in line with widespread recognition that tailoring services to the individual may substantially improve outcomes and treatment success.
- Commissioners expressed that personalisation was more applicable and appropriate in tier 4 services which had been modernised and well integrated with other tiers of treatment.
- Commissioners agreed that aftercare and wraparound services were often key determinants of treatment success.
- Commissioners varied in their opinion of where the emphasis of investment should be when considering the broader tiers of treatment. In terms of tier 4, some interviewees expressed a desire to see increased investment, while others expressed a desire to reduce or reallocate investment elsewhere.
- Commissioners agreed that the investment issue was not simply a question of increasing funding but that further research would help define an optimal balance in the trade off between increasing capacity and improving quality.
- Commissioners described how an important aspect of the challenge to streamline, improve effectiveness and improve the value of tier 4 alcohol services, was changing the culture, perceptions and belief of policy makers and stakeholders.

5.0 Recommendations

- Assess the feasibility of conducting in-depth needs assessments by area, including analysis of client occupancy levels. To assist in this task, explore the potential to derive Prevalence to Service Utilisation Ratios (PSURs), including appraisals of the accuracy of required data.
- Where possible, ensure the utilisation of consistent and robust monitoring processes throughout services of all constitution types and across areas. Work with service providers to ensure all services routinely submit accurate data to the NDTMS.
- Consider investment in the development and utilisation of robust performance indicators; support World Class Commissioning by commissioning based on performance wherever possible.
- Appraise the potential to create a referral template, which may be applied to a given area and that aids in the selection of service provision according to the level of client complexity or condition. Where there are shortfalls in service information, appraise services for clinical expertise and refer to specialists based on specialist need. Consider the potential to implement and utilise such a template across referral sources to improve referral pathways and reduce the proportion of non-attending clients.
- Assuming specialist commissioning is disbanded (as proposed) attempt to maintain a collaborative approach to commissioning across PCT areas and ensure the handover and transitional period is carefully managed and overseen to avoid service destabilisation. Encourage the involvement of the SHA to oversee localised PCT and D(A)AT commissioning.
- Analyse the potential to reduce incentives for PCTs not to under-spend; consider the feasibility of allowing PCTs to re-invest a proportion of saved funding.
- Where data are available, utilise overarching monitoring information to assess the feasibility of balancing low occupancy levels in some services or areas with excessive waiting lists in other services or areas.
- Consider investment in the modernising and integrating tier 4 alcohol interventions with the other tiers of alcohol and drug treatment; where possible develop and enhance links with the lower tiers of treatment, community-based services, aftercare and wrap-around services.
- If agreed and deemed appropriate by the individual, their care manager and involved services, consider the potential to utilise community-based detoxifications for dependent drinkers with relatively less complex needs.
- Consider focus and investment in the ongoing development and improvement of a shared, cross-area, evidence-based manual for inpatient detoxification programmes and psycho-social interventions.
- Consider the potential to implement modularisation and individualisation of tier 4 alcohol services with a view to improving the cost effectiveness of interventions and tailoring treatment to the individual. Assess the effect of modularisation and individualisation on treatment efficacy and assess the feasibility of their incorporation into mainstream tier 4 alcohol services.
- Where possible, consider trialling innovative mechanisms, such as 'Virtual Wards', and evaluate the ability of such mechanisms to reduce currently observed inefficiencies in referral and treatment engagement processes.

- Consider the utilisation of system models, such as ‘Dynamic Modelling’, to provide an overview of gaps in service provision, to map treatment journeys and to record the movement of individuals between tiers of treatment and the community.
- Appraise staff moral and counsellor case load as key determinants of treatment success.
- Develop, support and encourage ‘in & out’ patient groups as part of peer-led support, especially in the context of improving the transition from tier 4 services back to the community.
- Consider the potential to develop educational elements of tier 4 alcohol treatment, including the incorporation of family and friends in this process, where possible.
- Encourage the development of strategic educational and preventative mechanisms in the community, especially for young people.
- Consider the feasibility of appraising, developing and utilising non NHS-led services, where satisfactory performance can be demonstrated. Assess the potential to utilise such services for appropriate clients to reduce waiting times and out of area referrals.
- Consider the potential to offer block purchased contracts for services where consistent performance can be demonstrated.
- Consider the potential to offer trial spot purchased contracts for relatively newer services, where performance has yet to be robustly demonstrated.
- Continue the investment and development of independent service user forums and, where possible, utilise derived information to improve and integrate specific aspects or processes of tier 4 alcohol interventions.
- Consider appraising and addressing the cultural beliefs and stigmas surrounding alcohol dependency and tier 4 alcohol treatments among relevant stakeholders and the wider public.

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7.0 Appendices

Appendix 1 - Individuals in contact with Wentworth House for structured alcohol treatment, 2008/09

Individuals by Gender:

Sex	Total
Female	84
Male	163

Individuals by Ethnicity:

Ethnicity	Total
White	245

Individuals by Age:

Age	Total
20-24	7
25-29	12
30-34	26
35-39	44
40-44	51
45-49	46
50-54	31
55-59	18
60-64	7
65+	5

Individuals by Discharge Reason:

Discharge Reason	Total
Still in treatment	-
Dropped out/left	15
Moved away	-
Other	-
Treatment completed	6
Treatment completed alcohol free	190
Treatment declined by client	7
Treatment withdrawn/breach of contract	25

Individual by Referral Source:

Referral Source	Total
Substance misuse service	161
Hospital	9
GP	-
Community Alcohol Team	76

Individuals by PCT of Residence:

PCT	Total
Ashton, Leigh and Wigan PCT	51
Blackburn with Darwen PCT	7
Blackpool PCT	6
Bolton PCT	12
Bury PCT	12
Central Lancashire PCT	28
East Lancashire Teaching PCT	26
Heywood, Middleton and Rochdale PCT	17
Manchester PCT	17
North Lancashire Teaching PCT	-
Oldham PCT	13
Salford PCT	13
Stockport PCT	12
Tameside and Glossop PCT	18
Trafford PCT	12

Individuals by Secondary and Tertiary Substance Use:

Secondary Substance	Total
No secondary substance	192
Heroin	10
Methadone	8
Other opiates	-
Benzodiazepines	5
Amphetamines	5
Cocaine	8
Crack	-
Cannabis	16
Other drugs	-
Tertiary Substance	Total
No tertiary substance	223
Heroin	-
Methadone	-
Other opiates	-
Benzodiazepines	-
Amphetamines	-
Cocaine	-
Crack	-
Cannabis	6