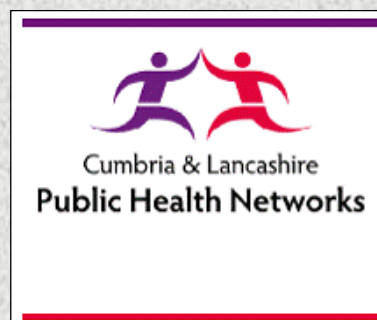
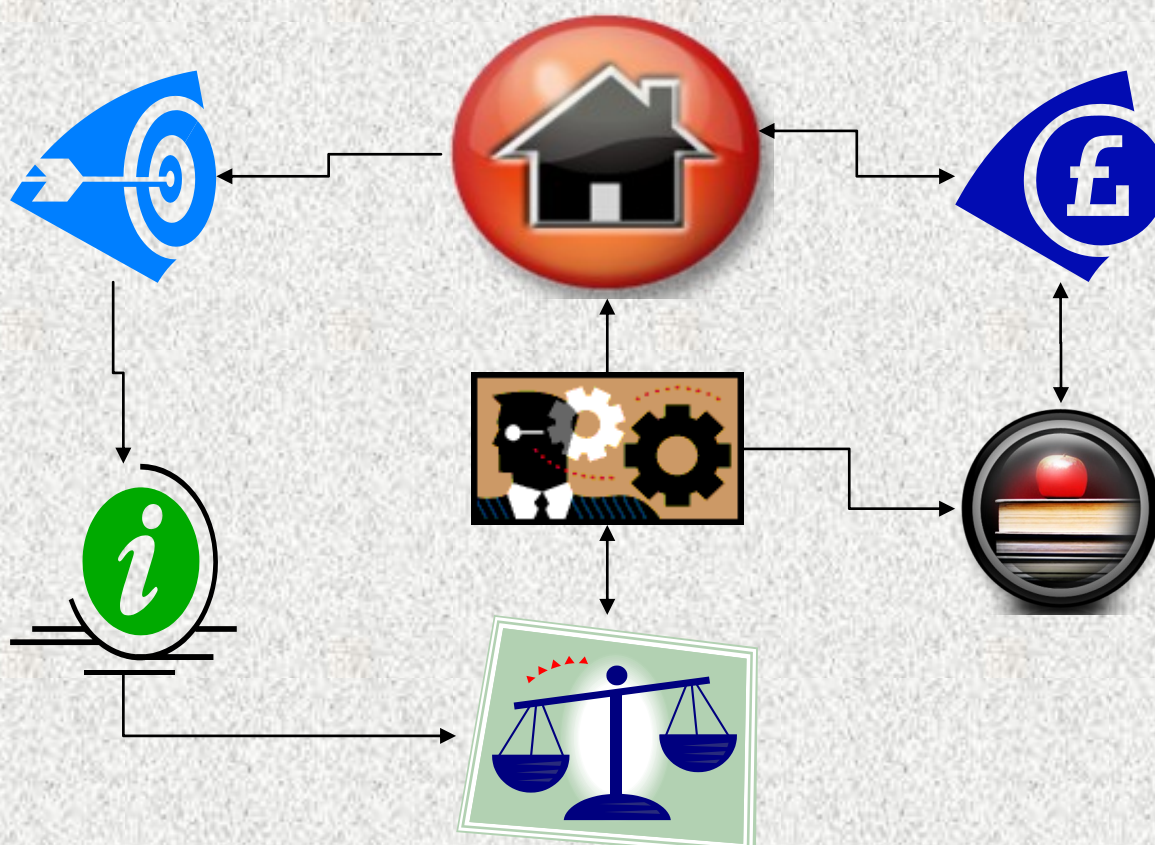


Evaluation and Review  
of Tier 4 Alcohol Treatment  
Services in the Cumbria and  
Lancashire Alcohol Network:  
Executive Summary



[www.cph.net](http://www.cph.net)



Simon Russell  
Ayesha Hurst  
Adam Marr

Centre for Public Health, Research Directorate  
Faculty of Health & Applied Social Sciences  
Liverpool John Moores University  
Kingsway House, Hatton Garden  
Liverpool, L3 2AJ  
t: 0151 231 8794



[www.cph.org.uk](http://www.cph.org.uk)

# 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, 2006), 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 for Substance Misuse (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 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 (2008) 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. Engage 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.

## References

National Treatment Agency for Substance Misuse. (2008). Improving the Quality and Provision of Tier 4 Interventions as Part of Client Treatment Journeys: A Best Practice Guide. NTA.

National Treatment Agency for Substance Misuse. (2006). Models of Care for Treatment of Adult Drug Misusers: Update. NTA.

National Treatment Agency for Substance Misuse. (2005). National Needs Assessment for Tier 4 Drugs Services in England: Research Briefing 16. NTA.