Alcohol treatment: pathways and outcomes

a report of the practitioners event supported by the GLA, LDAN, LDAPF and other partners

September 2012
The Fourth Alcohol Practitioners Forum was held on 24th February 2011 at City Hall, with the theme of “alcohol pathways and outcomes in London”. As with previous forums, the event was well attended with a range of practitioners from across London. The day explored the variation between alcohol treatment pathways in London and how these could be improved. The morning session was largely spent undertaking a smaller group treatment mapping exercise along with a speed networking session where delegates had a chance to explain their own pathway and learn from their colleagues. The afternoon session focused on alcohol treatment outcomes and how these can be measured and improved. This report is a write up of the day. The London Drug and Alcohol Network (LDAN) facilitated the planning of the event and supported the production of this report.
SESSION 1

London alcohol treatment pathways

Focused on the differences between various alcohol treatment pathways in London. There were presentations from Graham Lettington from Bexley Council detailing Bexley alcohol treatment pathways, Pamela Menzies-Banton from Foundation66 on Lambeth alcohol pathways and David MacKintosh from London Drug and Alcohol Policy Forum on their ‘service user pathways’ research. Session 1 was chaired by JAG Chair Paul Jenkins.
Bexley alcohol pathway

Graham Lettington
Bexley Council

Graham Lettington from Bexley Council outlined the current Guide to Care Pathways in the borough. The guide was produced with the aim to ‘develop and agree an integrated service pathways document and map of services’. When creating their Guide they considered the role of the Alcohol Strategy Group, and consulted the Models of Care for Alcohol Misuse (2006) and the Guidance for Developing Local Integrated Care Pathways (2006). The Guide details what services are available to each particular tier. Graham also addressed substance misuse among young people in Bexley, highlighting Bexley’s four tiered framework model developed by the Health Advisory Service (2001).

The Guide was distributed throughout Bexley to alcohol practitioners, alcohol training attendees, GP surgeries and is available online. To view Bexley’s Guide to Care Pathways, visit: http://www.alcohollearningcentre.org.uk/_library/care_pathways1_Bexley.pdf

Lambeth alcohol pathways

Pamela Menzies-Banton
Foundation 66

Pamela Menzies-Banton from Foundation66 outlined the number of drinking adults with alcohol disorders in Lambeth. Lambeth has an adult population aged 16 and over of 225,649 with just under a quarter (50,967) identified as having an alcohol disorder.

Pamela explained that their workforce was comprised of 2 Assessment and Treatment teams (2 sites), 1 Continuous Care Team, 2 GP Shared Care Teams, 1 A&E Alcohol Liaison worker and 1 SP Funded Alcohol Outreach worker.

Pamela also detailed the following processes to establish their multi-disciplinary workforce:

• Developing one vision through a series of events.
• Training needs analysis using survey monkey.
• Prioritise training needs using local expertise.
• Establishing clear leadership and management-weekly meetings, steering group and forums.
• Establishing clear clinical supervision, clinical group supervision, clinical meetings and team meetings.

Foundation66’s vision is to create a single pathway to treatment and a single care plan which will begin at assessment and stay with the service user until treatment exit. Their key aim is to improve the service user experience.
David MacKintosh outlined the London Drug and Alcohol Policy Forum’s ‘Service User Pathways’ research. The LDAPF brought together some 30 individuals, whose backgrounds included those currently accessing services: family members, former service users/volunteers, service practitioners, and policy makers. Participants plotted their journeys, identified where problems arose on each pathway and discussed how these were, or could have been, overcome.

It was found that working in this way produced a longitudinal view of an individual’s experience over months and years. It provided a powerful commentary. The research also provided evidence of what worked and what did not. Participant feedback indicated that the following worked:

- On-going support.
- Active involvement from key practitioners (e.g. GPs, social workers).
- Support with harnessing “Recovery Capital” (family/housing).

The research group found the reasons hindering success were:

- The possibility that service users could fall out of the system due to either relapse or funding.
- Gaps between elements of service provision.
- Some professionals lacked an understanding of presenting issues, especially when addressing mental health issues.
- Lack of knowledge regarding available services.
- No allocated key worker.
- A lack of support from family.

David emphasised the need to ensure that any treatment structure should consider the length of recovery journey individuals can go through and be sufficiently resourced.
Group Work

JAG Alcohol Forum Group Work Feedback: Mapping Pathways in London

Below is a summary of the opinions and experiences of attendees which emerged during the Treatment Pathway Mapping exercise:

**Arrest referral**

**Positive/solutions**

- Make/enable Drug Intervention Programme (DIP) to deal with alcohol.
- Identification and Brief interventions (IBA) should be offered in arrest referral schemes in police custody.
- Use police officers to deliver IBAs or at least to hand out NHS literature.
- Police + DIP support to develop alcohol arrest referral as has been started in January 2011 in Greenwich.

**Barriers**

- Conflict between agencies working in police custody settings, which makes it difficult to support clients with complex needs.
- “Tug of love” (sic) between alcohol, mental health and Substance Misuse (SM) services for complex cases.
- High volume of clients with no link to a borough (NFA) arrest referrals can’t access community support or links to other boroughs. Access to treatment also an issue for particular groups with no recourse to public funds.
- No resource in custody for arrest referral - DIP workers are prevented from engaging with alcohol clients because of home office restrictions on the way the DIP Main Grant is used. (This is now part of the funds provided to the Mayor’s Office for Policing and Crime – Police and Crime Commissioners outside of London).
### Courts

#### Barriers
- No equivalent to Restrictions on Bail (ROB) for alcohol users.

#### Positive/solutions
- Would help if probation staff were trained to provide brief interventions.
- More Probation Officers trained and delivering IBAs.
- Alcohol Treatment Requirements (ATR).
- Probation Officers to do more 3 way meetings with client and treatment services.
- Need better links with Drug and Alcohol Action Teams (DAAT) and probation.
- Development of substance misuse/offenders housing.

#### Barriers
- Waiting times for treatment affecting ATR compliance and outcomes.
- Lack of communication or clarity for clients on ATRs.
- Blockages, lack of consistency over sanction implementation when an offender breaches their ATR.
- No or little DAAT funding set aside to develop ATR day programmes.

### YOS

#### Positive/solutions
- Swift assessment and referral.
- Clear process for referrals, possibly based on ASSET (screening tool).

### Prison (treatment/and or detox in prison)

#### Positive/solutions
- Appropriate housing referral and advice.

#### Barriers
- No time for any work to be done.
- No liaison - re work done from CARAT to community organisations.
- No interventions in prison for homeless people with multiple sentences averaging at 6 weeks.
- Limited intermittent or no available treatment in prison post-detox.
- Lack of long term treatment in London prisons.
- Loss of accommodation.
- No mental health assessments/joint working feedback whilst in prison on 2/3 months sentences.
Criminal Justice System (under 12 months)

Positive/solutions

- Southwark is going to use an Integrated Offender Management (IOM) team to address this group's substance misuse needs.
- Referral to community alcohol service on release proactively by prison staff.
- Probation worker that hold case loads could benefit from training to empower them to refer clients to community services themselves.

Barriers

- No information after ATR is completed.
- Not linked in with community services as well as it could be – dependent on borough arrangements and sign up to London Probation Trusts (LPT) information sharing protocols.
- Blurred boundaries and expectations on service functions between probation and community services.
- Under developed through care from prison to YOS to probation.

Probation (treatment in community)

Positive/solutions

- Approved Premises (AP).

Barriers

- Lack of staffing in prison in regards to probation affects the opportunities to capitalize on abstinence in custody and consequent resettlement work.
- Lack of evening services for those offenders (and others) who work.
- Detox provision length of time varies.
- Resources - funding pots do not recognize poly substance misuse.
Participants then turned their attention to looking at the pathways for young people.

**Schools/Colleges**

**Positive/solutions**
- Should start with education and awareness.
- Lewisham alcohol and drug education training in schools by person appointed to do this work.

**Negative**
- Who refers? Teachers/Nurses? There is a lack of knowledge about alcohol.
- No consistent identification.
- PSHE not statutory and this undermines the importance of the issue.

**Youth clubs**

**Positive/solutions**
- Annual alcohol workshops and outreach workers satellites.

**Outreach**

**Positive/solutions**
- Lewisham Community Education Project Outreach – they provide support and advice on drugs/alcohol misuse to the local community.
- Outreach with young people’s sexual health (recognises links and shares resources).
- Travel and hand holding – workers visiting services with YPs.
- Communication.

**Barriers**
- Information for parents/not involving/targeting parents.
- Need more information for young people.
- How are we picking up issues/identification not consistent.

**YouTis – Tiers 2/3 within**

**Positive/solutions**
- Positive – specialist workers and protocols in place.
- There needs to be a promotion of outreach to other services.
- Asset tool and drug/alcohol tool (DUST) used together.

**Barriers**
- Poly drug use and other issues.
- Cultural acceptance of alcohol use.
- DAAT leads and funding – focus on adult needs, poor funding levels.
Social Services

Positive/solutions
• Specialist social services – drug worker linking with YOS well. In the same building.
• Satellites – transition age groups.

Barriers
• Lack of social media campaigns, there should be more promotion.

Sexual Health

Barriers
• Current pilot screening is for over 16s. Otherwise there is no referral pathway.

CAHMS

Positive/solutions
• Lead substance misuse workers linking with YOS drug workers. Clear processes.
• Dual diagnosis workers.

Barriers
• CAMHS do not want to refer clients to YPSM service.

A&E

Positive/solutions
• ‘Champion’ works well.

Barriers
• There is a pathway in place but it’s not very active.
• Few alcohol liaison nurses.
• No recognition of need.
• Information sharing – attendance slips to school nurses but no-one else. Not consistently shared with other agencies.

Local Authorities

Solutions
• Embedding treatment in new local arrangements.

Barriers
• Funding and staffing cut backs.

Adult SMU

Barriers
• Lack of knowledge, liaison and communication.
• Picking them up in adult services with chronic liver disease.

Looked After Children/Local Children’s Trust

Positive
• In-house provision.

Hostels

Barriers
• Lack of resources for YP.

Positive/solutions
• Good communication and clear referral paths.
• Need to bring parents and peers into process.

Barriers
• Commissioners with no clinical experience.
• Lack of policy/evidence base.
• Lack of a consistent screening tool.
• YP not being identified, questions are not being asked.
• Not a priority.
• Lack of support to hostels and to young people in them in terms of sharing experience.
• Lack of clarity re young people definition – U18/U19/U25 and key concern age range is 16-25.
• Lack of resources, evidence base and therefore funding for residential/rehab.
Screening/Brief Interventions

Positive/solutions
- SIPS project research – Brief Intervention given to many in A&E – follow up from research is showing that Brief Interventions are very effective.
- Brief Interventions at satellite services.
- Hospitals need to identify their “frequent flyers” and link treatment with community teams.
- Information on what support/help is available is important at this stage.
- Need balance of prevention, early identification and intervention.
- Lambeth training pharmacists in IBA: http://www.alcoholpolicy.net

Barriers
- Specialist staff having their time wasted. Conducting Tier 1 interventions as other staff/agencies are not trained or confident to deliver these.
- Funding – the number of front line workers is decreasing due to cuts.
- Lack of referrals, commitment and training.
- Out-of-date screening tools.

GPs

Positive/solutions
- GPs should act as champions for their patients and work closely with alcohol treatment services.
- Easy to use, non-time consuming screening tools for GPs.
- Alcohol liaison worker at GP surgery.
- Clinical champions in surgery to drive practice of IBA.
- GPs should deliver pre-detox groups to prepare service user for detox expectations and post-detox abstinence based groups.
- GPs should be approached to publicise alcohol services and Brief Interventions.
- Brief Intervention satellite services save GPs extra work.

Barriers
- GPs often lack knowledge of resources, interventions and services available.
- Failure to recognise alcohol as an issue, especially for under 18s.
- GPs detoxing without the service user being linked into specialist services.
- No “seizing the moment” to link patients into community services.
- Long waiting lists in primary care service for alcohol clients, clients are not seen in time of need.
- Screening/triage – inappropriate referrals to Tier 3.
- Unclear referral pathways slowing down treatment.
Positive/solutions
• A&Es deal with residents from a multitude of areas.
• Extended Brief Interventions clinic at A&E.
• Targeted outreach using hospital detox on repeat attendees.
• Mobile alcohol workers to meet service users at home/elsewhere.
• Where there is care coordination e.g. worker following through journey from A&E to treatment then aftercare.
• Specialist identified worker builds relationships and presents evidence of IBA efficacy, local evidence and outcomes.
• Clinical champions in A&E to drive practice of IBA and training opportunities.
• Brighton Hospital – joint working with YP substance misuse/offending/police/liaison staff.
• Alder Hey Children’s Hospital, Liverpool Alcohol work.
• A common Models of Care triage/referral form should be used to facilitate information sharing.
• Detox initiated at the hospital to be continued in the community.

Barriers
• No national recording of alcohol data for attendances.
• Patients leaving before they are seen.
• Cut back in nursing liaison posts.
• Lack of consistency due to A&E shift patterns.
• Very few referral pathways for under 18s.
• Ambulance capacity in highly active night time economies.
• Funding panels do not always understand alcohol.
• Some screening tools are too long, not suitable for A&E, though ‘PAT’ is good.
• A&E staff are resistant to screening and brief interventions.
• A&E staff are often disinterested and have negative attitudes towards dependent and other drinkers. Some hold the view that people with addiction issues have a lack of will.
• There is no follow through after being in A&E so detoxes are repeated.
• CDAT can only work with what they are commissioned to do i.e. no binge drinkers.
• A&E starting detoxes and not completing them, expecting a rapid response from CDAT (CDAT has a lack of medical cover).
### Self Help

**Positive/solutions**
- Peer champions.

**Barriers**
- Treatment system is geared to dependents and those with chronic problems; little is done for binge drinkers.

### Treatment Service Assessment

**Positive/solutions**
- A good comprehensive assessment is crucial.
- Standard and concise assessment form and process.
- GP and A&E workers can undertake community alcohol service assessment and will accompany alcohol service staff to meet service user.

**Barriers**
- If they are polyusers, there needs to be a better partnership working to address other issues at the same time e.g. Domestic violence, drugs.
- Hostel referrals difficult – Wet vs. Dry hostels.
- Mental health services pass the buck back to GPs.
- Poor physical and mental health of clients when referred to Rehab.
- Lack of provision for dogs though some providers offer limited places.

### Treatment Tier 2/3

**Positive/solutions**
- Key worker for clients from pre-detox throughout to counselling.
- Psycho-social interventions.
- Handholding to appointments.
- Multi Disciplinary Case Management Forum.
- Life skills training.

**Barriers**
- Lack of training for workforce.
- Drug and alcohol clients together – how will that work?
- Lack of joined up working in boroughs.
- Resistance to the opening of a Patrinex clinics due to funding.
- With Tier 3 clients there are often repeated assessments.

### Detox

**Positive/solutions**
- There needs to be a seamless transition from detox to Rehab.
- Early hospital discharge through development of detox policy that bridges hospital and community service to finish detox.
- A&E referral pathway into Tier 3 services.
- Established core pathways e.g. criteria for Tier 3 and Tier 4 services.
- Community detox.
- Counselling + Group work.

**Barriers**
- There should be more thought and support for home detox.
- Disputes over safety.
- Disagreements- Nurses vs. Doctors vs. Management.
- Lack of community support.
- Self discharge.
- Is detox the only solution?
### Residential Treatment

**Positive/solutions**
- Dedicated social workers who know the services and can care manage the process.
- Skilled Rehab staff providing treatment for clients with very complex needs.
- Good communication between care managers and Rehabs.
- Rehabs providing free aftercare.
- Free family and adolescent groups.

**Barriers**
- Good research done but it has been disregarded that Rehab works.
- Naïve commissioners: micro manage, they have complex clients but still expect simple results.
- Poor and inappropriate assessment of clients for in-patient services.
- Will lose funding or stop accepting clients if judged by standard treatment performance targets.
- Lack of resources and funds.
- Dilution of care management role despite evidence.
- Criteria too tight for access.

### Aftercare

**Positive/solutions**
- Good aftercare projects appearing like SHP.
- SMART Recovery with support from providers, but need adequate training to deal with risk issues, not short courses.
- Links to aftercare should be throughout the journey.

**Barriers**
- Do not like the term aftercare – community care applies at various stages and does not just follow residential.
- Aftercare means decent housing and jobs.
- No real “out of hours” services.
- No provision for child care.
- Not well invested because the outcomes of aftercare are not well evidenced.
- There should be more focus on “12 step”.
- Evaluation of Tier Four residential could be improved.
- Housing: workers not equipped to work with alcohol clients.
- Client being pushed into private rented sector after treatment.
- Housing options: very hard to keep abstinent if you return to the same housing environment.
SESSION 2

Alcohol pathway examples

Alcohol pathway examples were the focus of session 2 which was chaired by David Mackintosh from LDAPF. Rob Fitzpatrick from Confluence presented his research on alcohol-misusing offenders from which he developed a list of recommendations on how to improve alcohol interventions. Identification and Brief Advice (IBA) was explored later in the session by Matthew Andrews, from the Regional Public Health Group (RPHG). He suggested that despite IBA being an effective and cost efficient alcohol intervention tool, uptake has been sporadic.
A Label for Exclusion: Support for Alcohol-Misusing Offenders

Rob Fitzpatrick
Confluence in partnership with the Centre for Mental Health

In the course of this research, over 100 commissioners, managers, practitioners and users of services were interviewed and national stakeholders were consulted. There was also a detailed scoping of services and perspectives in Wiltshire and Devon. The findings indicated:

- An under-resourcing of alcohol provision.
- Variations in joint commissioning practice.
- Misalignment between the objectives and targets of health and criminal justice commissioners.
- Concern about the sustainability of services.
- Lack of equivalence between alcohol and drug commissioning.

Rob’s research also produced an extensive list of recommendations:

- In an unclear and contested commissioning environment, pragmatic joint responses are required.
- The evidence base for offender alcohol interventions needs to be developed.
- Service users should input commissioning processes.
- Preventive approaches are vital.
- Alcohol training should be available to all front-line staff.
- Identification and Brief Advice (IBA) should be provided by all agencies.
- The exclusion of alcohol misusers from mainstream services needs to be addressed.
- Services should be available at all stages of the criminal justice pathway services and should be responsive to women, younger adults, BME groups and perpetrators of domestic violence.
- Voluntary sector agencies add value and expertise.

The full report can be accessed at:
http://www.centreformentalhealth.org.uk/pdfs/label_for_exclusion.pdf
Identification and Brief Advice:
Where to now?

Matthew Andrews
Regional Alcohol Manager – London, Regional Public Health Group (RPHG)

Matthew Andrews, London’s Regional Alcohol Manager, from the RPHG outlined the ‘story so far’ in regards to Identification and Brief Advice (IBA). Evidence shows it to be one of the most effective alcohol intervention tools. Moreover, the cost savings from IBA are undisputed. IBA has now been rolled out in Emergency Departments (ED) and Primary Care settings. Despite the evidence of IBAs effectiveness, Matthew outlined reasons why the take up of IBAs has not been as successful as hoped:

- Despite efforts to spread IBA across London, there is still a problem with uptake.
- The case for IBA still does not seem to have been effectively made to the frontline staff who need to be delivering it.
- Emergency Departments – there has been a continued resistance and apathy towards the implementation of IBA.
- Primary practice – take up and delivery is flawed in many cases.
- Still a lack of acknowledgement that alcohol is a significant problem and burden on the NHS.

Suggestions on how to make the system better:

- Screening by ED reception staff – it is currently considered the best practice approach for ED assault data collection.
- Dedicated, wrap around Primary Practice approaches to Tier 1-2/3 treatment?
- Online screening with referral to brief advice providers.
- IBA teams – contracting screening teams to deliver screening through all health and social care contact points with follow up referrals where needed.

Matthew completed his presentation by proposing some questions that need to be asked to determine the future of IBA. How do we find out what will work and how can we get the workforce on side? And, how will the new commissioning environment change things?
SESSION 3

Outcomes

Chaired by James Morris, from the Alcohol Academy, explored current and future alcohol outcome measures. Don Lavoie from the Department of Health discussed Payment by Results, how it will operate and what will need to be in place for it to work efficiently. Alcohol Concern’s Don Shenker examined alcohol outcomes and advocated a number of tools including the Alcohol Star. The NTAs alcohol needs assessment was presented by Hannah Lindsell.
Don Lavoie, from the Department of Health’s Alcohol Policy Team outlined what Payment by Results (PbR) is and its purpose. PbR, first introduced for the acute sector in 2003/04, at its simplest is just a list of prices: \( \text{Price} \times \text{Activity} = \text{Providers’ income} \). Essentially, the money follows the patient/service user; PbR does not affect the total amount of money available but he suggests it does provide a clear and transparent method of funding. Don highlighted that PbR will lead to greater investment in proven interventions, better care leading to better outcomes for service users and more productive discussions between commissioners and providers. He also suggests it will lead to bench-marking for both providers and commissioners.

Don also outlined what will be needed for PbR:

- A national approach to classification for needs based clusters – allocating service users to defined and distinct needs based clusters, with designated review and payment periods for each care cluster.
- Nationally utilised individual needs assessment tools.
- Best practice needs based packages – defined packages of care, following best practice guidelines and seeking to reduce unacceptable variation in practice. Each package would detail the essential elements for treating each care cluster.
- An individual outcome measure.
- An appropriate Minimum Data Set.
- Costing of best practice packages.
- Indicative tariffs (unit costs) – a guide price to inform local price setting and support the use of national currency prices (where possible) for each of the currency units. Quality criteria would be credible prices with transparent calculation.
Measuring Alcohol Outcomes

Don Shenker

Chief Executive, Alcohol Concern

Don Shenker, Chief Executive of Alcohol Concern discussed why alcohol treatment outcomes need to be measured, the best way to evidence outcomes and what central government, local authorities and GP Consortia should do next.

Before outlining the various ways in which alcohol outcomes could be measured, Don suggested there were four main reasons why it was important to measure these outcomes:

• To have a national database to evidence the value of alcohol services.

• There would be local evidence of need and of outcome success, also showing what was value for money.

• For services measuring internal processes.

• Ability to see the service user journey.

Don followed this by giving a brief overview of current tools which measure the severity of an alcohol problem or dependency. In particular, he focused on The Alcohol Star. The Alcohol Star enables workers and clients to measure progress with ‘softer’ outcomes, both holistic and subtle change. He suggested it is an effective and popular motivational tool that can be used as an integral part of support planning and review. A pilot of the Star found that the consumption measurement was a good indicator of success in other areas of a client’s life. Moreover, 86% of the clients who showed an increase on their Alcohol Star score had decreased their alcohol consumption and a further 7% had remained abstinent.

A number of further issues on outcome measures were summarised by Don as the following:

• The treatment sector must lead the discussion.

• PbRs has to reflect health and social gains, not just consumption.

• Need to build capacity to introduce a national outcome monitoring system for alcohol.

• Services can only work well with proper funding.

• Is there a risk that those who are judged to be too difficult to treat will be left behind?

• Will anyone innovate if they are not being paid to do so?

• PbR may lead to a cash flow problem for smaller agencies.

He then ended his presentation by offering suggestions as to what the Government should do next:

• The Government needs to recognise and reward alcohol services who save the taxpayer money.

• A national system is required to feed into local health and GP commissioning.

• PbR must be shaped by sector experience and support planned investment in alcohol services.

• There needs to be better data capture on assessment of need across social/health issues.
Hannah Lindsell from London NTA outlined the findings from the Alcohol Annual statistics from 09/10.

There are currently 111,381 clients in contact with structured treatment aged 18 and over who cited alcohol as their primary problematic substance, and a further 31,733 clients aged 18 and over who cited alcohol misuse as an adjunctive problem to a range of other problematic substances.

The median age of clients at the first point of contact was 41, 65% of clients were male and 88% were White British; other ethnic groups accounted for no more than 2% of clients. On presenting for treatment 4% of clients had No Fixed Abode and a further 10% of clients had other housing problems.

With regard to referral source - 37% were self referrals and 21% were GP referrals, with onward referrals from other substance misuse services accounting for 12% of clients.

The most common type of intervention was ‘structured psychosocial’ with 45% of clients receiving this treatment modality in their latest journey.

Of the 63,632 clients exiting treatment in 2009/10, 48% had completed treatment successfully and were no longer dependent on alcohol.

The 2009/10 figures when compared with those compiled in 2008/09 show little difference. For both years, the age group with the largest proportion of new presentation was 40-44 and there was only a 1% change in the breakdown of gender, 65% of clients were male in 2008/09 and 66% were male in 2009/10. There was also a slight increase in the number of first interventions that had a waiting time of less than three weeks, from 78% (2008/09) to 79% (2009/10). The biggest change has been the percentage of clients receiving ‘structured psychosocial interventions’. In 2009/10 this was the most used intervention (45% of clients) whereas in 2008/09 this figure was 39%.

The full report can be accessed at:
Clients’ median age at their first point of contact with treatment in 2010-11 was 41 and 65% of clients in treatment were male.

Most clients were White British (88%), while other ethnic groups each accounted for no more than two percent of clients.

Where reported, 37% of clients starting in treatment were self referrals and 20% were referrals from GPs. Onward referrals from other substance misuse services together accounted for 11%.

The most common intervention type received was ‘structured psychosocial’ with 46% of clients receiving this treatment modality in their latest journey.

Of the 66,495 clients exiting treatment in 2010-11; 35,913 (54%) were no longer dependent on alcohol (had completed treatment successfully); a further 4,404 (9%) were transferred for further treatment within the community.
Acknowledgements

This document and the event which informed it, was made possible with the support of the Greater London Authority, the London Drug and Alcohol Network and the London Drug and Alcohol Policy Forum. We wish to extend our thanks to Esther Sample for her work on this and other practitioner events; Paul Jenkins, Matthew Andrews, Jane (Dave) Anson, Rob Fitzpatrick, Don Lavoie, Graham Lettington, Hannah Lindsell, David MacKintosh, Pamela Menzies-Banton, James Morris, Don Shenker and to all those who took part.

The London Drug and Alcohol Policy Forum was established in 1991 to help support London’s response to substance misuse and encourage joint working. It is funded by the City of London Corporation as part of its commitment to the Capital and the Nation.