HEALTH AND WELLBEING BOARD

9 SEPTEMBER 2014

Title:	**Substance Misuse Strategy Board End of First Year Report**
Report of the Corporate Director of Adult and Community Services	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision: No**
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Summary:

The Substance Misuse Strategy Board is a sub-group of the Community Safety Partnership which is responsible for addressing issues relating to drugs and alcohol in the Borough. It is attended by organisations from across the Community Safety Partnership, including: Public Health, the Police, NHS England, Job Centre Plus and substance misuse agencies. The Board discusses performance relating to substance misuse, the performance of substance misuse services and emerging substance misuse issues in the Borough.

The Board has now completed its first full year. This report is presented for information only and highlights end of year 2013-14 performance report (Section 1), work completed regarding the identified emerging issue of New Psychoactive Substances (Section 2) and the work of the Community Alcohol Detox as an example of good practice (Section 3).

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) note the content of these reports.

1. Performance of Substance Misuse Services

1.1 This report summarises the main performance points for substance misuse services in Barking and Dagenham for the 2013/14 period. This report uses official National Drug Treatment Monitoring System (NDTMS) data provided by Public Health England, where possible. These indicators are selected by Public Health England and distributed nationally.

Adult Performance - Drugs

1.2 **Public Health Outcome Framework –** This indicator looks at the number of individuals who have successfully completed drug treatment, as a proportion of the total case load and not re-presented to treatment within 6 months. The evidence of success for drug treatment systems is now on recovery, individuals successfully completing treatment and not re-presenting within 6 months. This indicator features within the Public Health Outcomes Framework.

1.3 The reports show that:

i) that the percentage of opiate users in treatment who have successfully completed and not re-presented to treatment within 6 months has increased from 9.6% in 2010[1] to 16.1% in 2013[2]. This rate is above the national average of 7.8% for opiate users, which is good.

ii) the percentage of non-opiate users in treatment who have successfully completed and not re-presented to treatment within 6 months has increased from 33.6% in 20102 to 47.8% in 20133. This is above the national average of 40.6% for non-opiate users.

1.4 **Numbers in Effective treatment –** In order for an individual to be in effective treatment they must have been in treatment for 12 weeks or more or have completed treatment in a successful way e.g. treatment complete, drug free. In the past, under the National Treatment Agency, this measure was used as the main performance indicator and was directly linked to funding. This remains an important measure, however the emphasis is now on recovery i.e. successfully completing treatment and not re-presenting.

1.5 The reports show that

i) the number of non-opiate users in effective treatment within Barking and Dagenham continues to grow with a 40.1% increase in numbers in effective treatment between January and December 2013 compared with the previous calendar year. This is high compared to the London growth of 5%.

ii) There has been a 5.8% growth in the number of opiate users in effective treatment between January and December 2013. This is above the national trend which has seen a 1.9% reduction.

1.6 **Prevalence and Opiate and Crack Users (OCU) penetration –** The University of Glasgow produce estimates of Opiate and Crack users (OCU) residing in the country and down to a local authority level. The Glasgow estimate gives an

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[1] Successful completions between January and December 2010 with re-presentations up to 30th June 2011.

[2] Successful completions between 1st October 2012 to 30th September 2013 with re-presentations up to 31st March 2014.

indication of the number of users residing in each area, as well as the rate per thousand population, based on the mid-year ONS population estimates. The latest Glasgow estimate is for 2011/12 and shows that Barking and Dagenham have a estimate of 1,079 OCUs, up 85 on the previous year's estimate but still lower than 2009/10 (1,102).

1.7 Between January and December 2013 Barking and Dagenham had 487 OCUs in effective treatment. It is estimated that in Barking and Dagenham we have a treatment penetration level of 45%, thus we have reached around half of the estimated OCUs within the local borough. This puts Barking and Dagenham slightly below the national average of 52% and slightly above the London average of 43%.

1.8 **Successful completions –** Barking and Dagenham are performing in the top quartile for both opiate and non-opiate successful completions as a proportion of those in treatment.

1.9 **Re-presentations –** A re-presentation is an individual who has completed treatment successfully, i.e. drug free, and has presented to treatment services again within 6 months using substances. This indicator shows the effectiveness of treatment and the sustainability of recovery. Re-presentations for opiate users has remained fairly static over the course of 2013/14 with 22% of individuals re-presenting to services in quarter 4. The re-presentation rate for non-opiate users has decreased in quarter 4 from 8.6% in quarter 3 to 5.9% in quarter 4.

1.10 The introduction of aftercare provision at all services enables individuals to access further support following their treatment and aid them with the transition from treatment life back into the community. The result of the aftercare provision will not however reflect in the official performance reports until the end of quarter 1 2014/15. This is because these reports look at individuals exiting treatment within a 6 month rolling period allowing 6 months for them to re-present to services.

1.11 **Harm Reduction –** As well as addressing substance misuse issues, services are tasked with addressing the physical health of individuals especially those where substance misuse is a risk factor. Blood Borne Virus (BBV) testing and vaccinating is therefore offered to all service users who enter treatment in the borough.

1.12 **Hepatitis B –** Barking and Dagenham have a better than national average commencement and completion rate for Hepatitis B vaccinations, 40% locally compared with 18.7% nationally. Barking and Dagenham do however have a lower than national average rate of individuals accepting the offer of a Hepatitis B vaccination, 31.2% compared with 43.1% nationally.

1.13 Services are currently offering service users Hepatitis B vaccinations at the start of their treatment when they are at their most chaotic. Services have been tasked to start offering Hepatitis B vaccinations at care plan reviews, where they are more stable and settled into treatment and at other points in their treatment journey where it is appropriate to offer.

1.14 **Hepatitis C –** Injecting drug users are at risk of contracting Hepatitis C especially if they are sharing injecting paraphernalia. Barking and Dagenham continues to demonstrate an excellent rate of Hepatitis C testing, with 90% of eligible clients (previous or current injectors) receiving a test in 2013/14.

1.15 **Drug Intervention Programme (DIP) –** DIP data recording has recently been moved from the Home Office to Public Health England and the NDTMS team. Barking and Dagenham are currently performing above the Metropolitan Police

Service level for percentage of DIP referrals to enter structured treatment. The quarter 4 Police Force Area DIP report shows that 64% of DIP clients who were referred by the DIP service engaged in structured treatment. This is above the 41% within the Metropolitan Police Service area. This is an increase from quarter 3 (61%).

Adult Performance – Alcohol

1.16 **Numbers in treatment –** The number of individuals aged 18 years and over accessing alcohol treatment in Barking and Dagenham over a 12 month period. Public Health England report that the number of people receiving alcohol treatment has shown a 15% rise compared to 12/13.

1.17 **Successful completions –** This indicator measures individuals successfully completing alcohol treatment as a proportion of the total number of individuals in treatment during the previous 12 month period. This demonstrates that individuals are being moved through the treatment system and not being held onto or becoming stuck in treatment.

1.18 The successful completion rate for quarter 4 (2013/14 period) was 33.7% which has reduced from 36.9% in quarter 3. The successful completion rate for the Community Alcohol Service in 2013/14 was 58% under the previous provider. Following a review of discharge procedures the new alcohol service now works with individuals for slightly longer to ensure that they are ready to exit treatment in a planned way. The successful completion rate has reduced from the previous year due to this longer work, however the quality of successful completions has improved. This extra work should lead to a reduction in the number of individuals re-presenting to treatment services.

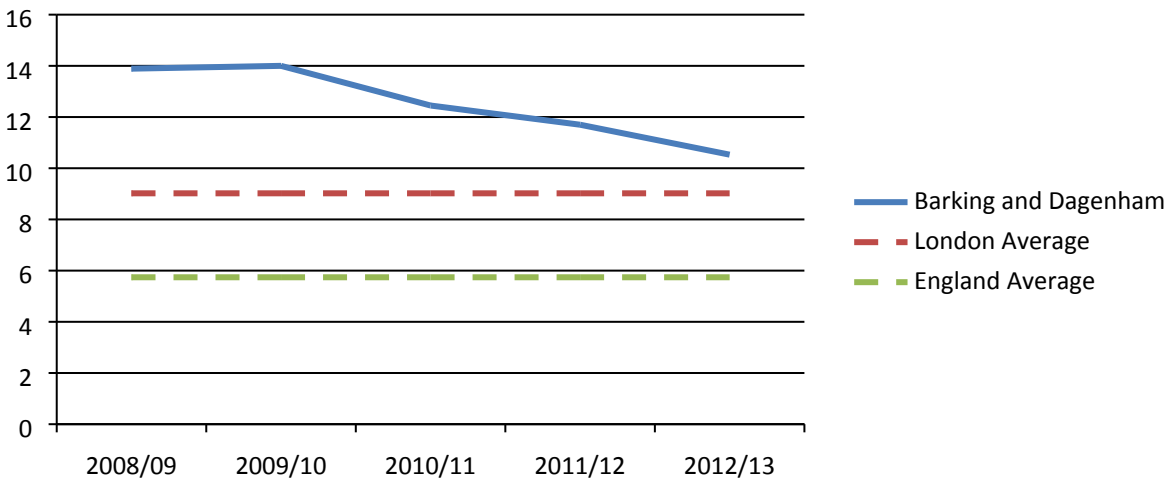
1.19 **Re-presentations –** A re-presentation is an individual who has completed treatment successfully, i.e. alcohol free, and has presented to treatment services again within 6 months using substances. This indicator shows the effectiveness of treatment and the sustainability of recovery. A high representation rate means poor performance for this indicator.

1.20 The re-presentation rate for Barking and Dagenham has reduced slightly from 12.3% in quarter 3 to 11.8% in quarter 4. This is in line with the national average (11.2%). This is a new measure that Public Health England is now reporting and is likely to support local performance against the Public Health Outcome indicator of alcohol related admissions to hospital.

1.21 **Alcohol Attributable Recorded Crime –**This indicator is calculated using the former UK Prime Minister's Strategy Unit's alcohol-attributable fractions and applying them to the total number of recorded crimes, based on urine tests of arrestees.

1.22 Barking and Dagenham has the sixth highest rate of alcohol related crime and violent crime in the country and the fifth highest in London per 1,000 population. Substance misuse reoffending is a CSP priority in the borough. This indicator has seen a consistent and significant decrease since 2008/09.

Alcohol Attributable Recorded Crime (Rate per 1,000)

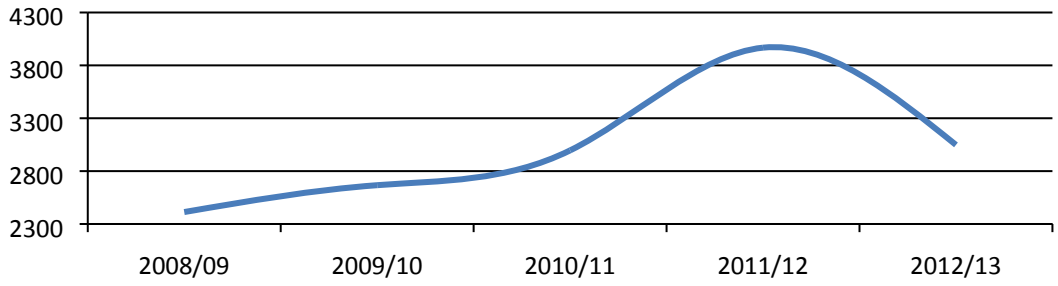


Source: Local Area Profiles for England

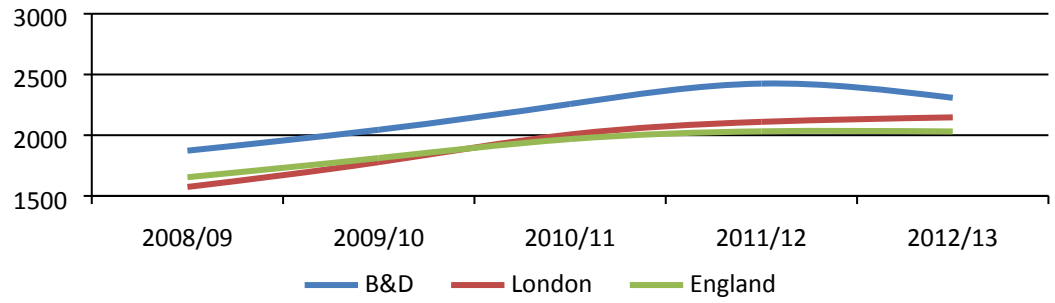
1.23 **Alcohol related Hospital Admissions –** This indicator measures the number of people who have attended hospital in relation to alcohol related harm and have stayed overnight and occupied a bed space. On average Barking and Dagenham has seen a 10% increase in alcohol-related admissions over the past 9 years (since 2002/3). In comparison the average for London and England was 12% and 10% respectively.

1.24 However, the official 2012/13 data shows the number of hospital admissions for the borough has starting to decrease 3048 (-5%) whilst the London average shows a 2.9% increase and the England average shows a 0.93% increase.

LBBD No. of admissions



Rate per 100,000 population



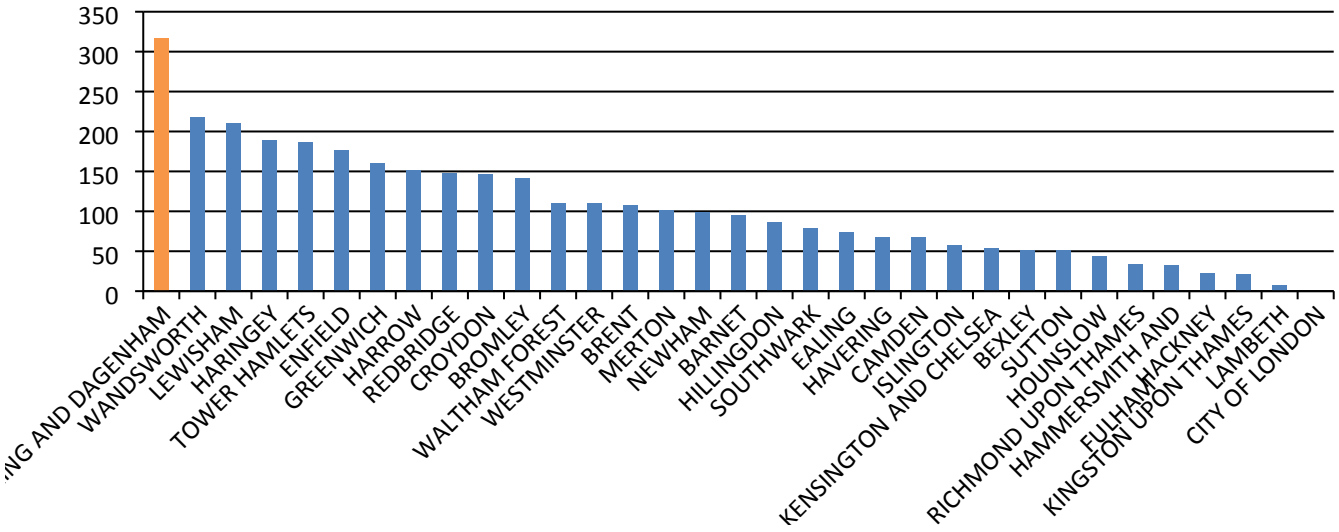
Source: Local Area Profiles for England

Young People Performance

1.25 **Numbers in treatment –** The number of young people accessing treatment during the 2013/14 period for both drugs and alcohol. This is a combination of individuals accessing treatment at SubWize and treatment with the substance misuse workers at the Youth Offending Service (YOT).

Barking and Dagenham have had 317 young people in treatment during 2013/14. On examination of the data behind the report it is possible to say that Barking and Dagenham had the highest number of young people accessing treatment in London from April 2013 to March 2014 and the 5th highest in England. This is due to the accessibility of services and clear signposting to services.

Number of Young People Accessing Treatment in London



Source: NDTMS YP executive summary Quarter 4 2013/14

1.26 **New treatment starts –** As well as looking at numbers in treatment it is important to look at the number of new individuals entering treatment at the service. This shows that people are moving through treatment and that new individuals are starting. The Young People (YP) services in LBBD have had 219 new young people accessing services between April 2013 and March of 2014.

1.27 The target for new starters into YP treatment for 2013/14 was 260. This target has not been met for the year; however the number of young people entering treatment in Barking and Dagenham reflects a reduction in the number of young people entering treatment nationwide. Despite not achieving the locally set target, Barking and Dagenham are currently out performing all other London boroughs with regards to the number of young people entering treatment.

1.28 **Hidden Harm referrals –** Although not officially reported to NDTMS, SubWize work closely with adult treatment services as well as social services and the police to work with children of individuals who are using substances. This hidden harm work is about supporting these young people to cope in the situation that they are in and to understand the substance misuse of their parents, carer or relative.

1.29 During quarter 4 of 2013/14 SubWize received 37 referrals for young people from adult services and 34 referrals from social services.

1.30 **School referrals –** Barking and Dagenham's SubWize team worked over the last couple of years to deliver a presence in the local schools. SubWize currently offer satellite sessions and groups in every school in Barking and Dagenham.

1.31 Barking and Dagenham have the 3rd highest number of referrals from schools in London with 61 individuals referred to treatment in 2013/14.

1.32 **Successful completions –** measures individuals successfully completing treatment as a proportion of the total number of individuals in treatment during the previous 12 month period. Barking and Dagenham had a successful completion rate for young people of 80% between April 2013 and March 2014. This is in line with the national average rate of 79%, however due to having greater numbers of young people in treatment Barking and Dagenham have a much higher number of individuals exiting treatment successfully.

Recommendations

1.33 These recommendations were made by NHS England from these performance figures. They were presented to the Substance Misuse Strategy Board and have been approved by the Board.

1.34 **Re-presentations –** All services to provide aftercare support, this started in October 2013. The aftercare provision supports service users after treatment and reduce the number of individuals relapsing and re-presenting to structured treatment.

1.35 **Numbers of young people in treatment –** YP services to continue to work with partners to engage appropriate young people into treatment.

2. New Psychoactive Substances

2.1 New Psychoactive Substances (NPS), also known as 'Novel Psychoactive Substances' and 'Legal Highs' are intoxicating substances that are not prohibited by UK law or have only recently been illegalised. Although the issue of NPS is not new, in recent years due to developments in 'chemical technologies, market availability, internet supply, trends in substance misuse, price and others' (Advisory Council on the Misuse of Drugs 2011) it has become much more prominent.

2.2 An initial report was presented to the Substance Misuse Strategy Board on the 25 February 2014, which proposed a set of recommendations for the Team to take forward to address the issue of NPS locally. These recommendations were agreed by the Board.

History

2.3 NPS have existed for a long time, mostly created as legal compounds to replace substances that become prohibited. In recent years, with developing technologies, NPS have become more prominent and available. Where there has been a decline in the use of illegal drugs nationally, the use of 'legal highs' has increased rapidly. It is estimated that 150 NPS were created in the last three years, this equates to a new compound being created every week.

2.4 The issue of NPS is particularly significant in the UK. According to the United Nations Office on Drugs and Crime, the UK has the largest market for legal highs in the European Union.

2.5 NPS can be broken down into four categories; stimulants, depressants, hallucinogens and synthetic cannabinoids. Common examples of NPS include 'spice' a synthetic cannabinoid and Alpha Methyl-tryptamine (AMT) a compound mimicking ecstasy.

2.6 Currently, NPS are readily available online and in 'Head Shops', which can be found on most UK high streets. Legislating against these sellers is a challenge, as enforcers must prove that the vendor is selling the product for human consumption. Further to this, many of the online sites used to sell NPS fall outside of UK jurisdiction making it almost impossible to legislate against them.

2.7 At present, UK law allows a 12 month temporary banning order to be placed on any new psychoactive compound that may have a detrimental impact on humans, while further investigations are made into its properties and potential illegalisation. Further to this, the government have launched a review into NPS, due for completion in mid to late 2014. It is anticipated that this will significantly alter UK drug legislation.

Risks Associated with NPS

2.8 Like all psychoactive substances, NPS can have a significant detrimental impact on the user's mental and physical health.

2.9 As the majority of NPS are initially legal they are readily accessible and often cheaper than illegal substances, making them an attractive alternative for drug users.

2.10 The term 'legal highs' is often used to describe NPS. This is problematic, as it reinforces the legality of drugs (many of which are in fact illegal). In addition, individuals may associate less harm with substances that are legal and be more inclined to use them,

2.11 Due to changes in legislation, it is now illegal to suggest that substances may be used for human consumption at point of sale. Where previously substances have included safety information and dosage guidance, packaging now simply states 'not for human consumption'. This has led to individuals being uninformed about what they are consuming and, in some circumstances, over-dosing.

2.12 Further to this, as NPS mimic other illegal drugs, individuals may be inclined to consume them in the same way, however NPS can often be more potent than the drugs they mimic and have increased side effects. For example, there are over 300 synthetic cannabinoids, which have been seen to induce psychosis.

2.13 It is estimated that one new psychoactive compound is created every week, this heightens risks, as newer substances have had less testing and thus both their short and long-term effects on humans are unknown.

What Can Be Done?

2.14 Scoping can be conducted to understand the availability and use of NPS locally. Having a better insight into the prevalence of NPS in Barking and Dagenham will enable appropriate strategy and resources to be developed to address the issue.

2.15 To further build the local NPS picture, work can be done to scope potential NPS vendors and to use legislation where possible to reduce the selling of NPS to residents.

2.16 Education can be used to build factual awareness for young people about the risks associated with using NPS, as well as harm reduction advice for those using NPS. CRI, for example, offer training and awareness building workshops in other Boroughs, which have been reported as an effective way of spreading the important information concerning NPS.

2.17 Training can be delivered to substance misuse and school staff to ensure that they are up-to-date on information around NPS and can disseminate this to young people and service users. Ensuring that schools are informed is essential to ensure that they can identify signs that a young person may be consuming legal highs and make appropriate referrals. It would be beneficial to have an NPS lead in every secondary school in the Borough.

2.18 Work can also be done with hospitals to identify admissions who present toxic symptoms and drug induced psychosis and to ensure that they are referring these individuals to the appropriate services.

Recommendations

2.19 This paper was taken to the Substance Misuse Strategy Board on 25 February 2014, and the Board agreed the following six recommendations:

Recommendation 1 - work with licensing to identify vendors of NPS in the Borough and to conduct spot purchasing

Recommendation 2 - work with hospital admissions in the Borough to identify toxic symptoms and drug induced psychosis and ensure appropriate referrals are made to services

Recommendation 3 - extend research into NPS with young people to gain more accurate and comprehensive results

Recommendation 4 - commission NPS training for substance misuse and PSHE leads in schools. It would be beneficial to have at least one individual fully trained in NPS in each service and school

Recommendation 5 - create a leaflet on the dangers of nitrous oxide and disseminate in the Borough, in particular to parents and schools

Recommendation 6 - deliver an education programme in all secondary schools in the Borough teaching young people about the risks of NPS and harm minimisation

Update Against Recommendations

Recommendation 1

2.20 At the Substance Misuse Strategy Board on 25 of February 2014, it was agreed to initiate Test Purchasing locally for NPS, in line with local principles. The results of the Test Purchase will be fed back to the Substance Misuse Strategy Board for discussion and agreement of further action.

Recommendation 2

2.21 The Young People's Hospital Worker has been briefed on NPS and is to deliver training with Accident & Emergency staff, informing them of signs and symptoms

that may identify young people and adults as having consumed NPS. Further to this, the substance misuse team are establishing a recording mechanism for the Young Person's Hospital Worker to ensure that incidents of NPS use are reported and appropriately referred. This will enable us to have a better understanding of NPS use in the borough.

Recommendation 3

2.22 A survey on NPS for young people continues to be conducted through Substance Misuse Services. To-date there have been 38 responses, which is a small sample, but gives a suggestion of local young people's awareness of NPS. The survey will continue to be deployed in order to broaden the Board's knowledge of young people's understanding and use of NPS in the Borough

Recommendation 4

2.23 PSHE leads have now been briefed on the issue of NPS. Further training, which will enable them to deliver NPS workshops with their students, has been planned for September 2014.

Recommendation 5

2.24 The copy for a Nitrous Oxide leaflet aimed at parents has been drafted based on research. Once approved, the leaflet will be designed and produced by the Council's Communications team to be disseminated in schools, GPs surgeries and Substance Misuse services.

Recommendation 6

2.25 The Borough's education lead for substance misuse is in the process of commissioning a project to deliver sexual and relationship education in schools. Part of this will involve drug education, including a section on NPS. Subwize continue to incorporate NPS as part of their substance misuse work in schools. The Substance Misuse Strategy Team are currently scoping the potential for an interactive workshop that is specifically about NPS. Subwize have also released an NPS newsletter to young people, which specifically warns of the risks around NPS and includes a young person's account of their experience of NPS.

3. Community Detox

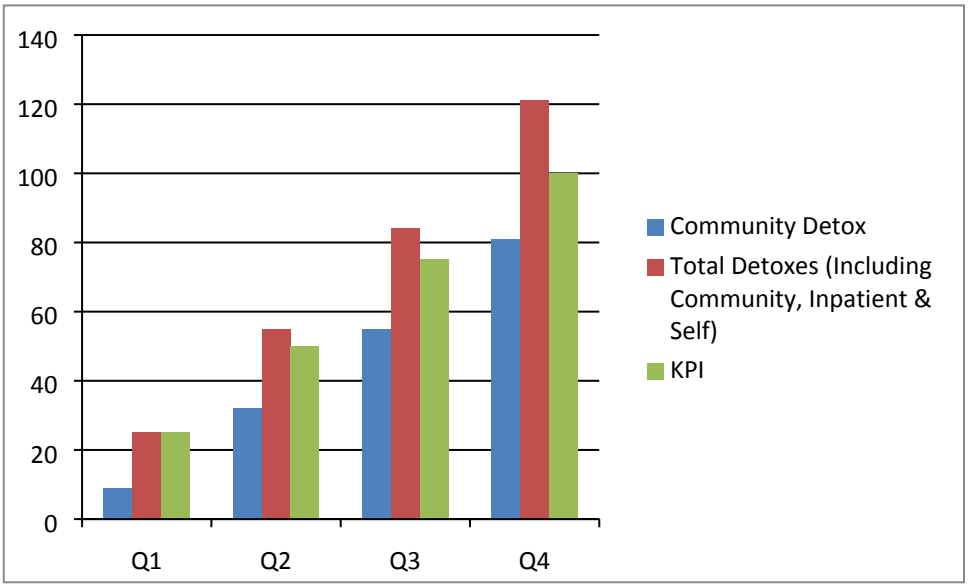
3.1 This section was prepared by CRI, the Borough's commissioned service providing community detox. The report demonstrates the effectiveness of the current community detoxification pathways at CRI Community Alcohol Service, as well as offering insight into the methods the Community Alcohol Service uses in order to secure positive outcomes for service users. At present the majority of community detoxes are provided through an ambulatory detox (where service users attend the service daily for monitoring with the clinical lead) with exceptional cases being offered a home detoxification (see below for more information). Policies and procedures were drawn up in 2013/14 to ensure that the detoxifications are clinically sound. With these procedures assured CRI are delivering detoxifications that sit comfortably within NICE guidelines which gives the greatest likelihood of delivering positive outcomes for service users.

Performance

3.2 Throughout the year the number of community detoxes have remained at a strong level, with a total of 85 detoxes completed. During the 3 full quarters of 2013/14 CRI have been running the service they have reached their targets, with the shortfall coming in quarter one when there was no premises and were only operational for 1 month.

	Community Detox	Inpatient Detox	Self Detox	Total
Q1	9	16	0	25
Q2	23	7	0	30
Q3	23	4	2	27
Q4	26	7	4	37

3.3 The graph below shows the number of community detoxes, and the amount of detoxes CAS supported in total (including self detox and inpatient detox).



3.4 Completions of detoxifications in 2013/14 was 100%, with every single service user seeing their detox through to the end, without relapse, demonstrating that CAS in only putting service users through for detoxification who are motivated and ready to do so.

3.5 There are actions in place to ensure that CRI are maximizing the amount of detoxifications that take place, whilst ensuring that they only carry out detoxifications when the client is ready, and it is deemed clinically safe to do so.

Pre-detox Work

3.6 Currently the service user is identified at assessment stage, or later in their treatment journey by their CRI keyworker as being potentially suitable for a detox. At this point they are referred to the clinical lead, who completes a full medical assessment to assess suitability for detoxification. This is based on the length of their drinking career, quantity of alcohol consumed on a weekly basis, indicators of dependency, social support etc. At this point a clear picture of previous withdrawals is also documented to exclude service users with a substantial history of withdrawal seizures, delirium tremens and so on. If suitable the clinical lead draws up a

chlordiazepoxide detoxification regime that would suit them based upon their level of alcohol use. They would also discuss the use of Carbemazepine as an anticonvulsant if appropriate and the use of Oxazepam for those with advanced liver disease or on the transplant waiting list or who have already had this. If the service user is deemed to be unsuitable for community detoxification at this point other options would be discussed, for example residential detoxification, or a reduction plan. At all stages of detox planning consults are held with the CRI Consultant Doctor who can advise on further medications recommended or other considerations to be made.

3.7 After medical assessment the service user starts to attend the pre-detox group. This was set up to last for a period between three weeks, (however this can be extended dependent on the service user's motivation, or if there is a delay in the GP providing relevant information). The pre-detox group covers the following topics:

- reasons for wanting a detox. Discussion of the negative effects of alcohol on health, mental health and social and family life and what this means to the individuals. Including body map. Importance of taking thiamine and vitamin B now;
- detox process itself. How to prepare and deal with cravings. Give leaflets for chlordiazepoxide and acamprosate. Give leaflets about nutrition and diet. Discuss sleep hygiene and ways to aid sleep and what to avoid; and
- discussion of the components of robust aftercare and the menu on offer at CRI and the benefits and research showing that attending aftercare has better outcomes.

During Detox

3.8 Whilst undertaking an ambulatory detoxification service users meet with the nurse daily to discuss any positive and negative effects that they are experiencing. Their blood pressure is taken and they are breathalysed to ensure that they are detoxing safely and have not resumed any drinking behavior.

3.9 During quarter 4 a new protocol was also been developed whereby during the ambulatory detox itself service users attend one group per day to offer further peer support. The group itself is designed to provide a forum for Service Users to openly discuss their detox experience and provide each other with feedback and support to further enhance the intervention. At this stage they are also introduced to Foundations of Life group, so that they can start to experience the groups that will be available to them post-detox. The full detoxification timetable can be found below.

3.10 The ambulatory detox length will vary according to the level of prior alcohol use however on average, detoxification lasts between 7-10 days.

Post-Detox

3.11 Following the completion of a detox the service user is passed back to the keyworker, who will ensure that the pre-agreed post detoxification aftercare package is in place, and the service user is being provided with adequate support to remain abstinent, as well as being informed and encouraged to attend mutual aid groups within the Borough.

Home Detoxification

3.12 In some instances, it may not be suitable or possible for a service user to commit to the full timetable expected of the ambulatory detoxification. Examples of this include:

- physical health problems such as chronic obstructive pulmonary disease, heart disease, advanced peripheral neuropathy and orthopaedic problems such as on the waiting list for hip replacement;
- psychiatric illness such as social phobia and agoraphobia, paranoia as part of major psychiatric diagnosis i.e. paranoid schizophrenia;
- reasons that prevent them from entering certain parts of the borough due to injunction and court orders; and
- the frail and elderly.

3.13 In the above cases the clinical lead would make the assessment that a home detoxification may be more suitable. In these instances another CRI nurse who is contracted to work flexible hours will visit the service user in the morning and the evening to monitor the service users health and wellbeing, and complete the same clinical checks that would take place in the ambulatory detox as mentioned above. During the home detox the nurse remains in contact with the service users keyworker to provide updates and ensure that the aftercare package is set up on completion of detoxification.

Case Study

3.14 CRI were able to offer a home detox to a service user who has a diagnosis of agoraphobia. This home detox, coupled with regular home visits from the outreach worker, has allowed this service user to access a full service, despite her mental health diagnosis.

Barriers and Recommendations

3.15 Although the community detoxification pathway is working well at present there are still actions that can be taken to ensure it runs even smoother. Currently, there can be a delay in gaining the relevant information from GP's (for example blood results, medical history) and there can also a delay in the GP writing the required prescription in a timely manner. Although CRI works closely in partnership with a number of GP's more work can be done to improve these partnerships. CRI plan to deliver further training to GP's and deliver relevant literature, as well as attending relevant meeting (PTI and CCG meetings) to ensure that GP's are aware of the benefits of their community detoxification service to their patients, as well as their surgery outcomes and figures.

3.16 CRI will continue to review the community detoxification process and performance and will adapt and develop the process as and when the need arises. CRI will also be gaining some service user feedback of the new ambulatory detoxification process.