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**▶ Delivering service quality in alcohol treatment: a qualitative comparison of public and private treatment centres by service users and service providers.**

**Resnick S.M., Griffiths M.D.**

**International Journal of Mental Health and Addiction: 2012, 10, p. 185–196.**

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*This small English study poses fundamental questions about alcohol treatment services: whether private services suffer from an 'empathy gap' and NHS services from poor systems; whether opening up treatment choice to patients with a record of bad decision-making is a good thing; and whether there can be universal criteria for what counts as quality provision.*

**SUMMARY** Organisation of alcohol treatment in Britain is very fragmented both in numbers of services and treatment approaches. The NHS offers programmes to help patients control their drinking, but many private and voluntary (mainly charitable) sector services are based on the 12-step model which mandates abstinence. Specialist NHS alcohol treatment units are organised to deal with complex cases of problem drinking and are funded by public health commissioning bodies, whose primary purpose is to implement national health priorities within the context of the local community. Voluntary alcohol treatment agencies can provide services for a range of problem drinkers, and receive funds from various sources such as local authorities, funding charities, and public health commissioning bodies. These bodies may also fund places for NHS-referred patients at private alcohol treatment services, which also cater for patients who arrange or provide their own funding.

The result is a diverse and fragmented service environment which invites competition for funding and within which problem drinkers may lack the capacity to make appropriate choices. Numerous choices of treatment services allow movement from one to another and back again, creating a 'revolving door' which also shapes service expectations based on previous experiences.

To investigate these and other issues, 17 patients and 13 healthcare staff at an NHS and 25 and 15 at a private alcohol treatment clinic in the same town in the English Midlands were interviewed in depth, guided by a framework of topics probing their understanding of what 'quality' means in alcohol treatment and how it can be achieved. Interviews were recorded and coded around the same topics, and further themes were identified. The NHS clinic focused on day care and aimed at controlled drinking; the private unit was residential and aimed for abstinence. The latter's 16 beds included seven publicly funded for NHS-referred patients.

At the NHS clinic 88% of patients were unemployed. Of the 17 patients, 10 had previously attended the same service and 15 other alcohol treatment services. Staff were mainly men and averaged 12 years at the service. Patients at the private service were about equally split between being private and publicly funded. They stayed at the unit for on average 17 days. About a quarter had previously attended the same service and over 60% other alcohol treatment services. Around a third were in active employment. The staff sample were mainly women and averaged two and a half years at the unit.

## Main findings

Four key themes emerged from the analysis of the tapes: how service quality delivery is defined; funding of services; choice in alcohol treatment services; and service delivery processes and their measurements. All are explored in the featured article but not all in the account below.

Patients and staff at the NHS clinic saw quality as an empathic relationship between the two and good clinical care. Patients defined quality by their personal relationships with the healthcare team, the care they received, the attitude of the staff towards their problem drinking and the way they felt personally supported – for example, staff being "interested in you as a person". Staff saw quality as meeting patients' needs, which was achieved through training, their professionalism in building relationships with patients, and through "Providing a professional service, founded on evidence and best possible treatment to clients ... warmth, flexibility, accepting, humanistic".

Patients at the private clinic defined service quality in terms of achieving recovery from problem drinking and receiving a professional service. 'Professional' too was the term used about how service quality is delivered at the clinic though expertise, training, the structure of the treatment programme, and the physical delivery of services. Staff too described themselves as 'professional' and referred to qualifications, training, guidelines and knowledge as ways they deliver quality.

The study city hosted up to 23 alcohol treatment services competing for patients and for funding. Patients could move between them and return to the same services. Several at the NHS treatment clinic were on their fifth treatment attempt, having accessed other alcohol treatment services *en route*. NHS clinic staff said, "People can buzz around between different services ... they can sometimes bump into what suits them but at other times the number of services makes it more complex", but also said the diversity "Makes it easy for the patients ... there is always an alternative for them".

Of the 15 patients at the private clinic who had accessed other treatment services, nine had experienced the NHS controlled drinking programme, but many said it had not worked for them.

At the NHS clinic, auditing and measurement of service delivery appeared vague and inconsistent and there was little emphasis on measurement as a core or meaningful activity. In comparison, the private unit had a pre-admissions process for NHS-funded patients, a patient feedback process, and processes for auditing and monitoring practices. Performance monitoring took place at six-monthly intervals. For NHS-funded patients the admissions process established by the funding health authority required a waiting time of at least six weeks, which staff saw as "healthy ... it proves motivation by the patient". Patients did not share this view, and saw the wait as too long compared to the few days private patients had to wait, who faced no such admission criteria. The funding authority also limits NHS patient access to private sector clinics to two attempts.

## The authors' conclusions

An overarching theme was the differing meanings of 'service quality' to the different stakeholders. Patients at the NHS service interpreted this as delivered through a good standard of clinical care and an empathic relationship with their service providers, characterised by trust, helpfulness, understanding, responsiveness, reliability, and non-judgmental attitudes. Of lesser importance were the tangible physical environment and facilities of the clinic.

Processes to monitor and promote quality were relatively lacking at the NHS service. In contrast, the private unit had a defined set of processes, systems and outcomes that has produced service provision based around process, professionalism, and profit. Patients expressed service quality expectations of achieving sobriety, recovery, and receiving a professional service. The unit appears to satisfy many of the NHS's quality criteria in terms of evaluation capabilities and performance measures, not in evidence at the NHS service. Although private clinic patients appreciated the professionalism of the staff, perhaps these emphases, coupled with mainly group rather than individual therapy, distanced staff from patients, impeded the forging of one-to-one relationships, and created an 'empathy gap' not apparent at the NHS service.

Another prominent factor was the range of services problem drinkers can access. Not only is there a choice of services, but these offer a choice of treatment methods and aims including an abstinence approach, specifically the 12-Step approach, and controlled drinking. Such choice legitimises patients moving from one service provider to another and back again "seeking the magic solution", as an NHS clinic manager put it, yet there is no evidence that one approach is generally more effective than another. Fragmentation is aggravated by the lack of ways to record and share patient progress through these different services, and by the fact that in alcohol treatment, GPs do not perform their traditional role of gatekeeper to specialist services.

People often become problem drinkers because of the bad choices they have made in their lives; providing extensive choices in treatment services may not help them or service providers. Choice creates a 'revolving door' practice enabling problem drinkers to move from one treatment service to another and back to the same services again; the NHS service believed it had a moral duty to keep its doors open. Whether choice can improve quality in healthcare is debatable, and it could undermine equity, as there will always be people better equipped to make choices than others. This revolving door has emerged partly because responsibility for services is fragmented; no single agency has either the power or the purse strings to effect or organise change.

There were also a number of inconsistent practices and systems, such as the stringent criteria for NHS patient access to the private clinic, contrasted to no such criteria for the NHS service or for private patients at the private clinic, for whom ability to pay was the prime criterion.

These findings suggest that alcohol treatment needs a grass-roots assessment of local services, a system for commissioning all treatment services, and a framework for health service funders to plan local services more effectively and to determine an appropriate level of funding. Measurements of performance need to be introduced into NHS services, focusing on the appropriateness of the treatment and tracking the progress of the patient through the treatment system. Private sector healthcare staff need to look beyond the treatment process and develop more awareness of a patient's individual needs. The study also identified a need for local services to work constructively together rather than seeing themselves as in competition for vulnerable patients.

Limitations of the study include its being conducted at just two treatment centres in one UK city, and the subjectivity of research based on the perceptions of participants rather than independent objective measures, though the latter are difficult to formulate.

**FINDINGS COMMENTARY** We should take seriously the limitation of the study to just two services. For example, though not the case for the studied service, other NHS services have a strong record of developing systems capable of monitoring and acting as the basis for improving performance and efficiency. Also one service was residential and the other non-residential; some differences between them might have been due to this rather than the private versus public split.

### Caring and professionalism

Nevertheless the study unearthed themes which might be of broader relevance. The NHS service was seen as a holistic carer centred on the patient, while at the private clinic patients appear to have seen themselves as buying a professional service which they expected to deliver the results they were paying for. It would have been good to know whether this attitude was equally expressed by the publicly funded patients at the private clinic. Looking to the future, if more publicly funded patients are given credits to purchase their own service mix, they too might come closer to the attitudes of the private patients in the study. With customers and purchasers to satisfy and a marketing job to do, while it came second on developing strong relationships with the patients, the private clinic won out in terms of processes which could monitor – and therefore act as the basis for improving – performance and efficiency.

Ironically, if the private clinic's staff had systematically and professionally assessed the evidence, they and their patients might have had to agree with this review that the clinician's professional characteristics have generally been unrelated to how well their alcohol patients do. According to the reviewers, the most consistent factor has been the clinician's ability to build a positive relationship with patients, the strength of the NHS service.

The importance of interpersonal warmth at NHS services was apparent in data gathered from patients at the Mount Zeehan alcohol treatment unit in Kent and from the nurses who assessed them. Though the six nurses were all well trained and supported and experienced, at one extreme fewer than the a fifth of their patients went on to engage with treatment, at the other, over three quarters. This was strongly related to the nurses' commitment to working with this set of patients, in turn related to their patients' experiences: "There is a strong sense that clients experience committed interviewers as interpersonally warm and less committed ones as interpersonally cold". Interpreting this data in the light of patients' comments, it was argued that the patient was actually assessing the worker, and that their main concern was, "How does the worker see me? Does the worker like me? Do they accept me? Are they critical of me?" Coming to the clinic in a fragile state with low self-esteem, their sensors were tuned for signs of rejection. When they sensed this, they tended to reject back and not engage with treatment.

The themes of interpersonal warmth and patients "sensitized to rejection" were also apparent at Massachusetts General Hospital in the late 1950s. A study there found emergency doctors' responses to the question, "What has been your experience with alcoholics?" were closely related to how many of their alcoholic patients had a year before followed through on a referral to the treatment clinic. The more a doctor evidenced personal (rather than coldly professional) concern in tone as well as words, the more likely their patients had been to treat the encounter as the start of a therapeutic relationship they wished to continue.

As at Massachusetts, ideally these virtues would be combined, a caring attitude to patients providing the motivation for developing strong systems which in turn enable caring to be consistently and effectively expressed in practice. For example, clinicians and services who care if some of their patients are falling behind and want to improve their prospects will be motivated to create and make good use of feedback from systematic and regular assessments of patient progress.

### Freedom to make the *wrong* choice – or the more doors the better?

Another major issue explored by the study was patient choice in services and treatment approaches. By no means everywhere will have the 'problem' of up to 23 alcohol treatment options, but where there is this range, the study identifies possible plusses and minuses. Among the concerns seemed to be that patients will rather aimlessly transfer, never fully committing to gaining recovery through one service because another can always be tried or re-tried, and that patients will not make the choices that are best for them in the longer run. An example might have been the private clinic patients who tried the controlled drinking programme at the NHS service but relapsed and were now trying the abstinence-oriented regimen at the private residential unit.

These concerns might be alleviated if local services cohered in to a network through which patients could move sequentially or in parallel or be allocated based on systematic criteria. This was not the case, a national concern for Department of Health support teams which visited hundreds of areas to investigate provision. Neither did GPs act as guide to which services patients should start with and provide continuity and coherence to the treatment journey. The consequences seem apparent in national statistics for

England, in which referrals from GPs in to alcohol treatment fall well below the possible caseload.

But as some study participants pointed out, choice at least means there is likely to be some starting or returning point which suits the patient and which may have a chance of success. Researchers responsible for the huge US Project MATCH alcohol treatment study stressed that treatment was not a 'technical fix', but a door through which patients can pass to actualise their impetus to get better. For them the implication of their findings were that "access to treatment may be as important as the type of treatment available to people with alcohol problems. If most treatments are similar in their effectiveness, the real value of having an array of treatments available is to promote healthy competition for the wide variety of people who would benefit from *any* treatment, but who would be more attracted to one because of reputation, convenience, or personal preference" (italics added).

From British studies we know that at least in the medium term, patients who opt for abstinence or to moderate their drinking usually do about equally well, even when the results are adjusted for differences in the severity of their problems and other factors associated with their choice. Eliminating or restricting one of these options risks deterring patients who prefer that choice from entering or completing treatment, without improving the effectiveness of treatment for the remainder.

*Thanks for their comments on this entry in draft to research author Sheilagh Resnick of the Nottingham Business School in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.*

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