Evaluation of Rapid Access to Alcohol Detoxification Acute Referral (RADAR)

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Executive Summary

The Centre for Public Health at Liverpool John Moores University was commissioned to evaluate the RADAR service (Rapid Access to alcohol Detox Acute Referral), a specialist alcohol detox facility based in Greater Manchester. RADAR has four main aims: reduce the burden on acute trusts; improve clinical outcomes for service users; provide improved experience for service users in a therapeutic setting; and demonstrate cost-effectiveness. In-depth interviews were conducted with 24 patients who attended the service within its first year. Interviews were also carried out with stakeholders, from each stage of the RADAR process. Both service user and stakeholder interviews focused on the individual's opinion of the service – what they were satisfied with and what they thought could be improved.

98 telephone surveys were also conducted with patients who attended RADAR within its first 18 months of operation. This survey concentrated on each individual's behaviour and attendances at the service in the six months both pre- and post- RADAR. These data were used to evaluate the cost-effectiveness of RADAR within its first two years. The telephone surveys were also analysed for patient outcomes, examining both frequencies and differences between the six months prior to individuals entering RADAR and the six months post RADAR.

Overall, service users and stakeholders were pleased with the service. Service users commented on how both the staff and environment contributed to a positive experience, whilst stakeholders commented on the success of RADAR meeting its four main aims. With regard to cost-effectiveness within RADAR's first two years, a projected saving of £1,320,921 was identified.

1 Background

Problem alcohol use is a major public health concern, as it is associated with a wide range of adverse health and social outcomes including alcohol poisoning, unintentional injury, violence and sexual assault. Alcohol related presentations to hospital have been increasing in the United Kingdom, with one of the major causes of such admissions being the occurrence of acute withdrawal symptoms[1]. More specifically, the burden of alcohol presentations to acute hospitals in Manchester has increased by approximately 150% in 2010/11 since 2002/03, with 13,783 admissions to hospitals in Manchester in 2010/11.[2]

In response to these issues, the RADAR (Rapid Access to alcohol Detox Acute Referral) service was established as an innovative pathway from A&E departments into specialist detox facilities. RADAR accepts referrals from eleven different acute hospitals across Greater Manchester and provides a comprehensive service, combining a range of psychosocial interventions with physical health management and aftercare planning. The RADAR service has four main aims: reducing the burden on acute trusts; improving clinical outcomes for service users; providing improved experience for service users in a therapeutic setting; and demonstrating cost-effectiveness. In accordance with these aims, the service focuses on certain subgroups of alcohol related admissions such as those who frequently present to acute hospitals known as 'frequent flyers'.

Despite the increasing number of people suffering from problem drinking in the UK and the growing cost to the NHS of treatment and care of alcohol related illnesses, service quality delivery in alcohol treatment services is not widely researched[3]. Therefore, this report presents data summarising the treatment and clinical outcomes among patients who undergo detox at RADAR. A thematic analysis based on the collection of qualitative data is also presented, as there has been little research on the service quality delivery of alcohol treatment services from the perspective of the service user[3]. The importance of such research becomes apparent when considering that at a national level alcohol services are under-funded[4]. Similarly, rapid access to such a service is very limited[5]. The current absence of data concerning the treatment and clinical outcomes among patients who undergo RADAR admission also highlights the importance of the current research.

The Centre for Public Health at Liverpool John Moores University was commissioned by an organisation independent of the service to evaluate the RADAR service through qualitative analysis of both stakeholder and service user experiences and also in relation to its cost-effectiveness for its first two years of service.

[1] Husain, O. M., Lynas, P. S., Totty, J. P., Williams, K., & Waring, W. S. (2012). Unplanned alcohol withdrawal: a survey of consecutive admissions to an acute medical unit in 2010 and 2011. QJM, 106, 43-49.
[2] Manchester City Council. (2012). 2012-2015 Manchester Alcohol Strategy.
[3] Resnick, S. M., & Griffiths, M. D. (2010). Service quality in alcohol treatment: A qualitative study. International Journal of Mental Health and Addiction, 8, 453-470.
[4] Alcohol Concern. (2007). 15:15: The case for better access to treatment for alcohol dependence in England.
[5] Ward, D., Murch, N., Agarwal, G., & Bell, D. (2009). A multi-centre survey of inpatient pharmacological management strategies for alcohol withdrawal. QJM, 102, 773–80.

Patient Profile

The majority of patients who entered RADAR within the first two years were male (67.5%), between the ages of 18 and 76, with a mean age of 44. Patients were most likely to be single (57.3%), unemployed (67.3%) and living in settled accommodation (83.4%).

Within the first two years that RADAR was open, 636 patients were admitted to the RADAR ward. An individual who presented at hospital three or more times in the preceding 6 months was considered to be a frequent flyer. Based on data of 418 patients, 41% had attended hospital three or more times and so were considered to be 'frequent flyers'. 30% of patients were with a community alcohol service when they were admitted to RADAR and 18% were in contact with mental health services at the time of admission.

Approximately half of those who attended RADAR presented at hospital with alcohol withdrawal (55.2%), with around one quarter presenting for reasons regarding their mental health (28.4%). The most common hospital for referrals to RADAR was Salford Royal (19.8%), followed by Manchester Royal Infirmary (12.7%) and Wigan and Leigh Infirmary (12.6%). The majority of patients were referred to RADAR from A&E (33.9%) and the Emergency Assessment Unit/Medical Assessment Unit (EAU/MAU) (29.4%).

The mean Alcohol Use Disorders Identification Test (AUDIT) score for patients on their arrival to RADAR was 31, with scores over 20 indicating dependence. Patients drank an average of 228 units of alcohol in the week before attending RADAR.

Telephone Survey Patient Profile

When leaving RADAR patients were asked for telephone contact details to allow them to be contacted for research purposes and to provide signed consent to be contacted. LJMU were provided with the contact details of 357 individuals who had been patients of RADAR in the first 18 months. Out of this total number, 98 people completed a telephone survey. This corresponds to a response rate of 27%, however it should be noted that in the vast majority of cases, the reason why a survey was not completed was due to reasons such as an invalid telephone number or an outdated 'pay as you go' mobile number, telephone numbers where confidentiality could not be assumed (i.e. a work or family member telephone number), no answer within five attempts or death of the individual. It should be noted that there were only 15 individuals (4%) who answered the telephone and declined to participate.

The majority of patients who took part in the telephone survey were male (67.3%), between the ages of 18 and 76, with a mean age of 44. Patients were most likely to be single (43.9%), unemployed (65.3%) and living in settled accommodation (86.7%).

Based on data of 98 patients who took part in the telephone survey, 17.5% had attended hospital three or more times and so were considered to be 'frequent flyers'. 34% of patients were with a community alcohol service when they were admitted to RADAR and 23% were in contact with mental health services at the time of admission.

Over half of those who attended RADAR presented at hospital with alcohol withdrawal (57.8%), with one quarter presenting for reasons regarding their mental health (25.6%). The most common hospital for referrals to RADAR was Salford Royal (27.6%), followed by Manchester Royal Infirmary (13.3%). The majority of patients were referred to RADAR from EAU/MAU (33.7%) and A&E (30.6%)

The mean AUDIT score for patients on their arrival to RADAR was 32, with scores over 20 indicating dependence. Patients drank an average of 224 units of alcohol in the week before attending RADAR.

Comparison of 98 telephone participants and 538 patients

In order to examine if the 98 telephone participants were representative of those who attended RADAR, chi squared was conducted on the data. A significant difference was found between the two groups regarding their relationship status [χ^2 (5, N = 625) = 12.7, p = .03, where those who took part in the telephone survey were less likely to be single. Those who took part in the telephone survey were also found to be less likely to be a frequent flyer [χ^2 (1, N = 419) = 16.74, p<0.05]. No other significant differences were found between the two groups.

(Please see appendix for figures and tables)

2 Participants

Interview recruitment was done in conjunction with RADAR. Letters of invitation alongside LJMU participant information sheets were posted out to the last thirty service users discharged from RADAR by the clinical psychologist. The invitation letters informed service users that they would be contacted directly by a member of staff from LJMU to see whether they would be willing to participate in the evaluation. RADAR continued to post out letters of invitation to patients who were discharged from the service until sufficient numbers (n=24) were reached. The service users were then contacted via telephone, and for those who expressed an interest in participating, interview dates were arranged at a time and place of their convenience. Written consent was obtained prior to each interview.

Table 1.1: Details of the participants interviewed

Participant	Gender	Age	Referring A&E	Admission date(s) to RADAR	Length of Stay	Current Abstinence Status
P1	M	51	Wigan and Leigh	October 2013	7	Not abstinent
P2	M	41	Salford Royal	October 2013	7	Abstinent
P3	M	51	Bolton	October 2013	7	Abstinent
P4	F	56	Trafford	October 2013	7	Unknown
P5	F	38	Bolton	October 2013	7	Not Abstinent
P6	M	42	MRI	October 2013	7	Unknown
P7	M	63	MRI	September 2013	7	Abstinent
P8	M	39	Salford Royal	October 2013	7	Abstinent
P9	M	35	Salford Royal	October 2013	7	Abstinent
P10	M	42	Bolton	August 2013	7	Not Abstinent
P11	F	45	Bolton	August 2013	7	Unknown
P12	F	45	Rochdale	October 2013	7	Abstinent
P13	M	51	Stepping Hill	July 2013	7	Abstinent
P14	M	52	Salford Royal	August 2013	7	Abstinent
P15	F	48	Salford Royal	July2013	6	Abstinent
P16	M	58	Bolton	October 2013	7	Abstinent
P17	M	40	St. Mary's	September 2013	7	Abstinent
P18	F	54	Wythenshawe	August 2013	7	Not Abstinent
P19	M	55	Salford Royal	November 2012	7	Abstinent
P20	M	58	Salford Royal	November 2012	7	Abstinent
P21	M	57	Oldham	November 2013	7	Abstinent
P22	F	62	Fairfield	June 2013	7	Abstinent
P23	F	34	Salford Royal	May 2013	7	Not Abstinent
P24	M	57	Oldham	January 2013	7	Abstinent
N=24						

3 Methods

The qualitative evaluation of RADAR is based on data collected from the following sources:

Table 2.1: Data sources for qualitative evaluation

Source	Evaluator	Sample	Data Collected
Patient Satisfaction Survey	Internal - RADAR	N= 235	Three open-ended survey questions: 1) what did you like about your experience at RADAR 2) what needs improving and 3) anything else to add
Service User Semi-structured Interviews	External - LJMU	N= 24	Range of open-ended questions to explore service users' experiences throughout the pathway from Accident and Emergency to discharge from RADAR, including the referral process, their stay within the RADAR ward and their engagement with community services.
Service Provider Semi-structured Interviews	External- LJMU	N=8	Range of open-ended questions to gauge service providers' experiences of utilising RADAR: achieving aims and objectives, development and implementation challenges, impact on patients, added value and unique features as well as suggestions for improvement.

Ethical approval for the service user and service provider interviews was granted by Liverpool John Moores University Research Ethics Committee.

Service User Interviews

Twenty-four semi-structured interviews with former service users of RADAR were undertaken (sixteen males and eight females). Face to face interviews were conducted by one male researcher who was on occasion, accompanied by one female researcher. Participants were asked to discuss their alcohol use pre and post RADAR, their visit to A&E, their referral to RADAR and their stay within the RADAR ward. Interviews were digitally audio recorded and lasted between 24 to 105 minutes. The interviews were transcribed verbatim and any identifiable data anonymised.

An interview discussion guide was developed, informed by the literature to explore the service user experience of RADAR.

Topics for discussion included:

- Experience of A&E prior to referral to RADAR
- Reasons for attending A&E when referred to RADAR
- Experience of the rapid referral process
- Knowledge and awareness of RADAR prior to referral
- Reaction to be being referred to RADAR
- Perception of RADAR

- Experience on the RADAR Ward
- Experience of aftercare
- Impact of RADAR Service
- Experience of other services
- Current alcohol consumption
- Suggestions for improvement to RADAR

Table 1.1 provides an overview of the service user sample. Two thirds of the participants were male (67%) and one third were female (33%). All were referred to RADAR from a range of acute hospitals across the Greater Manchester conurbation. Twenty participants had only been referred to RADAR once whilst four had been referred twice. All bar one service user stayed for the whole seven days. Sixteen participants self-reported abstinence at time of interview, five were not abstinent and three did not comment on their current drinking status. This success cannot be entirely attributed to RADAR as participants also accessed community based alcohol services once discharged from RADAR. However, many did suggest that their attendance at RADAR was very much a catalyst for their recovery.

Only four service users reported returning to A&E post RADAR – the reasons for attendance were not always alcohol-related. Although the evidence is from a small sample and must be treated with caution, it does suggest that RADAR has been successful in achieving one of its core aims: to reduce the burden on Acute Trusts in relation to alcohol related admissions.

Service Provider Interviews

Eight semi-structured interviews were conducted with key stakeholders of RADAR. Stakeholders were identified by RADAR and contacted directly via email by LJMU staff. Participant information sheets and consent forms were attached to the email. Interviews were conducted by one female researcher from LJMU, either face to face at the service provider's place of work or over the telephone; to accommodate busy schedules and heavy workloads. Stakeholders represented different stages of the RADAR process: those who refer patients to RADAR from acute care, those who work with patients in the RADAR ward and those who provide community drug and alcohol services to patients discharged from RADAR (see Table 3.1). Stakeholders were asked for their views on the purpose of RADAR, the development and implementation of the programme, its impact on patients, the added value and unique features as well as suggestions for improvement. All interviews were digitally audio recorded and lasted between 18 and 40 minutes in length. The interviews were transcribed verbatim and any identifiable data anonymised.

Table 3.1 provides an overview of the service provider sample.

Job Role	Number of participants	Role or relationship to RADAR
Alcohol Liaison/Specialist Nurse	N= 4	Make referrals to RADAR from A&E and ward
Nurse and/ or manager in Chapman-Barker/RADAR	N= 2	Work within the RADAR unit managing the joint unit and/ or supporting clients
Volunteer at RADAR	N=1	Originally a client of RADAR now volunteers within RADAR unit. Supports therapy sessions, talks to patients, general support
Senior staff member at a drug & alcohol service	N=1	Liaises with RADAR team to offer social support for patients when they come out of the RADAR unit. Sometimes visits clients at RADAR though this is mainly done by a support worker now

Analysis of Qualitative Data

Qualitative data management for all three studies was conducted using QSR NVivo (version 10), a computer software package that organises and analyses non-numerical or unstructured data for classification and sorting of information and examination of relationships in the data. The staged thematic analysis approach espoused by Burnard (1991; 2008) was used to analyse the data. This analytical process which is broadly interpretive began with familiarisation of the data. Responses were read and codes (annotations) were assigned to all text. Codes were then grouped into categories and emergent themes (recurrent patterns) were sought. Illustrative verbatim quotations are used to support the analysis in the narrative below.

Several limitations must be taken into account when interpreting the study findings. The study endeavoured to explore service user and service provider experiences of RADAR. However, the experiences are limited to a self-selected sample of service users and therefore cannot be generalised to all patients who have been admitted to the RADAR unit. The small number of service providers also limits the transferability of the findings. Moreover, the chaotic, complex and often transient lifestyles of the service users, coupled with poor physical and mental health prior to their referral to RADAR may have impaired memory recall, potentially leading to recall bias and issues with reliability and validity.

4 Patient Outcomes

Patient outcomes were identified by examining the self-reported data from the telephone survey conducted with 98 patients from RADAR who were in RADAR within the first 18 months that the service was open. The survey examined the 6 months before an individual entered RADAR and also the 6 months after. As the data is self-reported, accuracy relies on the individual giving honest answers, and also remembering details over a long period of, potentially chaotic, time.

Through calculating means and using Wilcoxon's test to analyse differences between pre- and post-RADAR, it was found that there were several significant differences. The average visits to A&E before entering RADAR were around three visits per patient (SD=9.28), while visits after were found to be around one visit per patient (SD=1.15), which was found to be a statistically significant difference between pre- and post-RADAR ($Z= -5.79$, $p<0.001$). The average amounts of visits to a GP before entering RADAR were around five visits per patient (SD=8.29), while visits after were found to be around three visit per patient (SD=5.8), this was found not to be a statistically significant difference between pre- and post-RADAR ($Z=-1.66$, $p=0.03$). An average for the amount of times that a visit to hospital had resulted in an overnight stay in hospital before entering RADAR was around two visits per patient (SD=9.31), while visits after were found to be less than one visit per patient (0.29, SD=0.65), which was found to be a statistically significant difference between pre- and post-RADAR ($Z= -2.13$ $p<0.001$).

In order to compare whether attending RADAR had an effect on attending alcohol services and self-help group, frequencies were analysed. Over half of the patients did not attend and alcohol service before RADAR (53%), in comparison to more than half attending after RADAR (69%). In comparison to this, when examining the amount of patients who attended self-help groups before and after RADAR, no difference was found with there being nearly a 50/50 split between those who did attend (48%) and those who did not (49%). Participants in the telephone survey were also asked to rate their alcohol use on a scale of 1 to 10 since leaving RADAR, with 1 being very controlled and 10 being uncontrollable. The majority of participants rated their alcohol use as very controlled (51.5%), with an average rating of three. Participants were also asked whether the quantity of alcohol that they were now drinking was more or less than before entering RADAR. The majority (86.9%) stated that they were now drinking less. When asked about their drinking within the last week, 37% stated that they had consumed alcohol, while 62% stated that they had not. An average amount of units consumed within the week cannot be calculated as several participants measured their drinking in the amount of cans that they had consumed, and did not state the size of the can. One participant had been drinking a half litre bottle of vodka and two, two litre bottles of cider a day, while others had four and six litres of cider a day. A participant who had less alcohol within the week stated that they had consumed 2 pints of 5.3% cider, and another had 3 pints of beer.

5 Patient Experience

Service user experiences are organised around two central themes: experiences of A&E and experiences of RADAR.

Experience of A&E

The referral pathway into RADAR is via A&E. Most service users had presented at A&E on multiple occasions and did so rather than going to their GP because they perceived that it was easier to access. They also had difficulties in keeping to GP appointment times due to the chaotic nature of their lives, in particular when drinking.

> *I'm in no state, I miss so many appointments when I'm drinking, doctors, dentists, ADS, all everything all I do is drink, nothing outside that window matters to me when I drink, when I really get into it. (male participant)*

> *Yeah, well… because if you, if you've took yourself to Accident and Emergency asking for help, there should be some help there when you need it shouldn't there? And I think that's what had happened a few days before, when me daughter said 'We seem to just be going round in circles. (male participant)*

A range of reasons were cited by the service users regarding their attendance at A&E. The majority had gone to A&E because of the health effects of their alcohol consumption or the side effects of undergoing an unsupervised detox with symptoms such as seizures, hallucinations and collapsing. Most reported varying lengths of stay in A&E ranging from a few hours to a couple of days before their admittance to RADAR. Some were confusion as to whether they were referred directly from A&E itself or from a ward in the hospital.

The majority of the participants considered themselves to be well treated in A&E. Most felt that the staff were understanding and non-judgemental. Some believed that this was due to the fact that they did not display any of the negative stereotypical behaviours associated with heavy alcohol consumption.

> *You know – being withdrawing and that, you're a little bit manic and… I suffer from hallucinations when I withdraw so I… I was probably out of it for the first couple of days anyway. But I felt well treated – I didn't feel neglected or condescended to or anything like that*. (male participant)

> *… they understood me more, … the reasons that I was there. I think they could see that I wanted to do summat about it.* (male participant)

> *I was quite coherent at that time. I wasn't abusive or loud or shouting or anything. I was quite compliant with whatever they said and only when I started shaking did I ask for some more medication which they brought straight away*. (female participant)

Well I'm not a violent drunk so I'm not a problem, I'm not like an issue in A&E, all I want is medication - some Librium really. (male participant)

A few participants did feel that some staff in A&E made negative assumptions about them because of their alcohol use. Others acknowledged that A&E was not considered the most appropriate service to access for detoxification.

You go in A&E and you feel a bit, cos a few times I've asked for a glass of water or something and they've gone yeh yeh I'm busy, in a bit and they just leave ya, you know, it's like, oh that's an alcoholic you know what I mean, you're labelled. They don't say anything to you, you know, you know, you know, you get that, it's that feeling that you get. (female participant)

Some people say if you go to well like A&E you're wasting their time cos only, you can stop straight away drink and what have you, you try to explain that is a progressive illness and what have you but no the staff were fine. (male participant)

Since attending RADAR the majority of participants reported that they had not had to access A&E for alcohol-related issues. Those that did use A&E have done so less frequently than they did prior to their admittance to RADAR.

Experience of RADAR

Lack of awareness and understanding

Findings highlighted that the majority of the participants had little knowledge and understanding of RADAR prior to their referral. The few who knew about RADAR had been admitted to the unit previously or knew of others who had been through the detox programme.

The alcohol nurse came from the hospital to see me and asked if I would like to go to RADAR and I didn't understand what it was… (male participant)

I hadn't no…no never heard of it. (male participant)

Some participants were of the opinion that greater awareness of RADAR and the way the service is run would have reduced their initial reservations about the referral.

No I could've gone that day and I said I'm not goin cos I thought ooh detox, I'll be locked up, nurses lookin down on ya because you're an alcoholic and I thought I'm not doin that but then three months after I was in and I loved it and I wish I'd of done it three months ago. (female participant)

A few service providers however expressed concern that as awareness of RADAR and its reputation grows, this could potentially lead to exploitation of the service by some service users. Examples of how patients were now demanding a referral to RADAR were cited:

> *I have had an occasion where people have made clinic appointments and they will quite adamantly sit there and say you will send me there, and I have had to say well no you don't come here that's not we do here. I can refer you on to the community alcohol team; I can refer you on to the XXXX Unit and you can have a look at detox, well I know somebody I know somebody who's been there, well that's not how it works. (Service Provider P1)*

> *Yeh there is an awareness of [RADAR] I don't know where patients find out this information, something came out when [colleague] first started she was telling me she was getting people phoning from Cumbria asking if they could come for a detox. (Service Provider P5)*

Some participants were familiar with the unit's history as a psychiatric hospital which raised concerns about their referral because of the associated stigma. This point was also raised by two of the stakeholders (the volunteer and a senior staff member from RADAR). They discussed how the location of the RADAR ward within Prestwich Hospital discouraged some patients from attending.

> *I asked him what that was an he said it's at Prestwich Hospital an immediately a said… am not going there, am a local guy and a knew all about what Prestwich was, a didn't know what it was now but obviously a was influenced by nut house, mental home, mental hospital, ad bin there before visiting. (male participant)*

> *Well a didn't, a was completely gobsmacked because a wasn't going to hospital a thought a was going to an that was quite, that was quite worrying cos Prestwich as a said, when we were children Prestwich was a mental hospital. (male participant)*

> *At the time I was really against it, I didn't want to come [to RADAR]...the stigma of Prestwich Hospital put me off...cause I'm local to here and I thought 'I'm not going into there, it's a mental health institution, I'm not interested. (Service Provider P6)*

> *Oh at Prestwich hospital and his instant reaction was 'I'm not going there' cause he remembered it as the old psyche bin...which, you know, and then the person was able to say, 'well you know it's a unit within and da da da'. But he's of an age where he could remember that. I mean, blimey, my mother used to threaten me with we'd get taken away to Prestwic.h (Service Provide P8)*

Referral to RADAR

Participants discussed their motivation for entering detox, often stating that they had reached a crisis point in their addiction to alcohol:

> *… it'd hit a bit of a crossroads and like, you know, it was either do something or xxxxx die I think. (Male participant)*

Yeah, the day before I'd literally got up and thought you know I can't, I can't carry on living this cycle 'cause when you involved in that loop, you know, you just can't see a way out of it erm… I wanted to stop drinking but I knew physically I couldn't completely but I couldn't find the level to, to cut down and financially I couldn't do it either and mentally I hadn't slept and hadn't eaten for… I must… Seriously I must have lost about 2 stone, 2 and a half stone, something like that… (male participant)

I needed to address my drinking 'cause it had just spiralled right out of contro.l (male participant)

The importance of readiness and motivation to engage with the process and willingness to participate fully in RADAR was perceived to be an important factor to successful detoxification by both service users and service providers. The participants themselves recognised that it needed to be the 'right time' for them to enter detox. Equally, taking personal responsibility for one's actions was cited as critical to success. Many believed that patients who left RADAR early were *"not really ready to address the problem".* Service users were keen to recommend RADAR to others who were struggling with their dependency to alcohol, provided they were committed to quitting.

I'd recommend it, I'd recommend it … I mean if you're definitely wanting to get off it, it'd an ideal place. You know if you're definitely serious about staying off it, it's a great place. (female participant)

Yeh if yeh. I..I'd recommend they don't go if if they are just looking at it as well, they're gonna have a drink, you need to to really want the help, but once you get it it's really er your best chance. (male participant)

... but I'd say to people yeah if you get given the chance for it for 7 days go in, participate, be active in what they're trying to do, go to groups and what have you, take what you can out of it and then I'm sorry but it's down to you. At the end of the day, it's down to you, once you leave RADAR. (male participant)

A range of reasons were given for accepting the referral to RADAR. These included reaching a crisis point, taking advice from medical practitioners and wanting to reduce the stress and anxiety felt by family members as a result of their addiction to alcohol:

I've seen her before and she said this time it's a really good idea that you go cos how many times are gonna keep comin in A&E keep being admitted with the same problem and not going to get treated for it. I was like let's do it, she said she'd been to the place and it was a very nice place, it wasn't like a hospital and er, you can have your own clothes and things like that and your own room which I didn't know… (female participant)

And after all the pain and everything that I put them through and they're still here I couldn't, you know I had to do something I just couldn't. (female participant)

cause it got to the point where… you know I thought… this has just got to stop you know… it got ridiculous so… (male participant)

Participants described mixed emotions when admittance to RADAR was confirmed. Some were hopeful, others were relieved that they were finally getting some help and support to deal with their problematic drinking.

…it's a wonderful, it's a relief to find that someone's taken you in, you're scared they're not going to take you, or they're not gonna help you, and you're gonna be stuck with this, horrible situation you're in detox in on the outside world without any help, so there's a relief to get into a bed and then there's a relief because I used the word angel, that somebody comes to you and would you be interested in going to a RADAR ward…(male participant)

I'd been that ill and to be honest, I'd been waiting, because I had gone to seek help, I'd been waiting for ages and I just wanted, ya know to get a start and get it done and get me life back on track. (female participant)

I got a bit of hope that I could sort something out. (male participant)

A few however were '*apprehensive' or 'scared'*. This was based on previous experiences at other detox programmes, their lack of understanding of the RADAR programme or their concerns about maintaining abstinence once discharged from RADAR.

I was feeling quite apprehensive really cos I've cos not, cos I've never heard of it before. (female participant)

… scared really, I suppose. I probably, I suppose at the time, I was scared of stopping drinking. (male participant)

I did want to stop but it's not, it's easy to go into RADAR, take the drugs and get detoxed, it's not so easy keeping it going afterwards. (female participant)

The majority of participants were pleasantly surprised at the speed of the referral process:

the nurse come to me, a got dressed when she said yer goin tonight, tonight was the word she used, it's a weird thing thinkin y'know they're gonna take me tonight. (female participant)

… I think I saw the alcohol worker… I think it was about ten o'clock in the morning and I think I was by tea time I was in … I was in RADAR. (male participant)

Some compared RADAR's referral process to other detox programme, citing how their previous experiences involved significantly longer waiting times:

> *Because, that's what people struggle with cos you can go, like, cos people can say like the they had to go through an alcohol worker, ya know, and get get referred to XXX, and you can wait weeks and weeks to get in, you could be dead by then if you're an alcoholic. (female participant)*

> *you know, constantly on that level of drinking cider just so his body's ticking over and you know, you know he's been in bits but you know he's been taken in now and there just seems something really wrong with the system. (male participant)*

Admittance to RADAR

Admittance to RADAR was for the most part a positive experience although some found it quite an intimidating process, in particular those who had never been through a detoxification programme before. However, admittance also engendered a sense of relief that help was at hand. The personalised treatment by the staff and the welcoming environment allayed many of their initial fears.

> *… the first, the first days a bit hazy… you know obviously it was a bit intimidating because I'd never done it before and was in such an anxious state anyway ... but I think the overriding thought I had in my head you know… I just…I just… it was just relief that I was actually going to get something sorted. (male participant)*

> *Very much, very much relief, it was very early in the morning, about four, four o'clock I think it was, there was a nurse, very nice to me, got me set up and it was a nice comfortable feeling. (male participant)*

> *I was greeted by a… a member of staff, I can't remember her name, who knew my first name which impressed me immediately… showed me to a room which impressed me greatly – I had my own personal room. (male participant)*

A few respondents felt '*privileged*' and '*very lucky*' to have had the opportunity to attend RADAR. Service users expressed gratitude to staff for the level and quality of care received.

> *But this time, e e, it was great I felt blessed really to go to this place, they kinda pick you back up really quickly, not just physically, mentally as well, you know, cos the level of support and the understanding was it was great. I remember leaving the place thinking that's a great place that, you know. (female participant)*

> *Given the quality and consistency within this service I have felt very privileged to have been here. There are many other who could also benefit … (male participant)*

> *I have enjoyed an excellent experience on the unit. The medical care has been better that I have experienced anywhere else and the culture among the staff is one of care and compassion. I have been given every opportunity to plan my recovery and now it is up to me. I am extremely grateful. (male participant)*

Think myself very lucky to have had the chance to detox in such an environment. (male participant)

Facilities

In general service users were positive about the facilities and food available to them at RADAR. In particular, the indoor facilities of the RADAR ward were perceived to be warm, clean and well equipped. The pleasant environment created an ambiance which was welcoming, relaxing and put the service users at ease which some suggested was imperative for recovery.

It's my first impression I got of that place was the friendliness, good people, you know, um, because when you've not been to one of those places before and ave just come from A&E and er, you know, um, the atmosphere is completely different you know, the understanding, they're on the same level, they're on the same level as as us people, which is good. (female participant)

The homeliness and restful atmosphere of the RADAR section. Eased my state of mind and as a result enhanced the hospital treatment. (male participant)

Relaxed caring atmosphere was put at ease as soon as the nursing staff welcomed me in. (male participant)

Clean safe environment, good food good staff including housekeeping. (male participant)

All service users had their own room which was generally described as basic but adequate. Several made the point that in the weeks prior to their admission to the RADAR ward, their living conditions had deteriorated quite significantly as a result of their loss of control over their alcohol addiction and therefore the facilities at RADAR were of considerable improvement by comparison. A few service users had issues with the comfort level of the furniture but most were positive about the size of the room and its cleanliness:

Oh the accommodation was fine I mean it's not luxuries , but you wouldn't need to be . Everyone had their own room and it was perfectly adequate for what you what you needed. They had washing machine facilities so you could wash your own clothes and everything. I mean it was a bit sometimes a bit like a prison, they only allowed you out for an hour n things like that at a time , but you could understand why it would be like that it's a difficult place. (male participant).

Its fine it's what you need, a bed, a sink, a wardrobe – that's it, all you need. (male participant)

…obviously it's not the Hilton hotel but probably the month before you go in there or the six weeks you are living like a tramp anyway cos that's what I do anyway. (male participant)

Participants were also complementary about the communal facilities that were available to them. They discussed how they felt the basic nature of their bedrooms was to encourage them to use the communal facilities with the other service users. Participants who had family members visit the unit commented positively about the space provided to accommodate this.

> *I've had eight children so the like took it in turns t'like who as coming up an there was a nice little family room erm cos two of me granddaughters came so we just went in there erm there's a tele and some toys and they did some drawin so that was nice nice comfortable erm nice place t'take yer family an like grandkids so yeah that was nice.* (male participant)

> *But you know, on, on the positive side I did meet some people who were in the same position as me and, you know, there was the communal room … so we could chat you know, and people who smoke could smoke outside and there was a tv so we all go to know each other a bit and the meals were, you know, were good and sort of a set times, sort of … a routine after three days I started to you know, feel better and made some friends, I mean I still like I said before you know, I still know a couple people I met in there. So I, I thought it was, you know … welcoming as, as it could be in that circumstance, you know. (male participant)*

Although service users were generally positive about the internal environment, some survey respondents felt that there was room for improvement outdoors. Insufficient space, general untidiness and little provision for non-smokers were cited. A few smokers felt their needs were not adequately catered for either.

> *Not much outdoor space to relax and enjoy. (male participant)*

> *Lack of a non-smoking outdoor area. (female participant)*

> *I think there should be better facilities for smokers. (male participant)*

Some participants were also surprised at the level of independence they were given whilst in RADAR compared to other hospital facilities, for example being able to do their own laundry and make themselves drinks:

> *There was a launderette you know, which a was surprised at erm y'could,y'know go and do yer washing an that.* (female participant).

> *Because you've got your own room, you've got the toilet – facilities, and you've got a utility room where you can do your washing, you've got a TV lounge, you've got a dining room, you can make yourself toast, tea, biscuit – well, basically anything*. (male participant)

Food

Many of the participants interviewed responded positively when asked about the food served on the RADAR ward. Some acknowledged that because of their addiction to alcohol, during the weeks prior to their admittance to RADAR they had a poor diet. A few reported putting on weight whilst in the unit.

> *I loved it, loved the food. The food was all homemade, not homemade but it wasn't like, it was like hospital food. Ya got three courses, ya got a choice of what you wanted, ya didn't just get what you were given.* (female participant)

> *Yeh yeh yeh, I was just getting calories down me anyway good, there was always stuff in the fridge if you needed it in-between meals. (male participant)*

Opinion was divided amongst survey respondents regarding the quality of the food. Whilst some were complementary, others were critical of the portion, quality and lack of choice, in particular for vegetarians. A minority of interviewees reported some organisational problems relating to meal times.

> *There was always a mix up with the vegetarian meals, and the kitchen do not seem to cater for vegetarians. (female participant)*

> *The food…they seemed to av trouble in ordering the right amount of meals, no matter what yer put on the menu yer never got it.* (female participant).

> *I was put on bed rest which is fine until some doesn't tell ya it's dinner time and ya get there at 2 minutes past and there's no food left. (*female participant)

Medication

The issue of medication was raised by some respondents. In general, service users were happy with the medication and treatment that they received at RADAR. Getting the correct medication enhanced the RADAR experience although for a few, the timing was problematic and several complained about an unwillingness to prescribe medication on discharge.

> *The only, the other thing I didn't like about it, when, if you're with RADAR, I felt you were treated a little bit differently from the people who were in there a long time because they got their meds first and we had to wait. (female participants)*

> *The staff obviously it's their game so they know what they are doing, they know if you're struggling and you get some more Librium or PRN or whateve.r* (male participant)

> *Medication a bit too late at night. (female participant)*

> *Sending me home with no medication feels like I'm being thrown out of a plane without a parachute. (female participant)*

Shared Experience

Admission to RADAR provided service users with opportunities to meet new people, to form new friendships and most importantly, to share their experiences with individuals in a similar situation. The benefit of talking to staff and peers who had experiential knowledge was considered a strength of the RADAR programme. It not only fostered understanding and learning but highlighted the fact that service users were not alone. Being able to see how others had recovered from their addiction was seen as encouragement to those who were trying to become abstinent and that this set RADAR apart from other services.

> *The RADAR staff as well had already been through the alcohol and drug thing so they work there now and I found they were really helpful as well cos they'd been through it themselves, cos some of the doctors like, they're just doing it by textbook, they're not really the person you should be speaking to it should be someone that's been through it there self.* (male participant)

> *Cos RADAR, it's like they've opened me eyes to, I wasn't on me own with the problem and how bad other people were and seeing people who were there like the nurses have got through their alcohol problem and how got a job that, cos there is life at the end of the tunnel, ya can get through it but you've gotta do it, you've gotta, it's gotta come from you, it can't come from anybody else.* (female participant)

> *The benefit of having the chance to talk to people who have similar problems to myself. (male participant)*

> *Learning from staff doctors and people going through the same experience as me, and learning new things as about myself and how to deal with things. (female participant)*

They reported how service users who had been there for longer would often help those who were new to the unit and that staff were very understanding and non-judgemental:

> *Yeah the people that had been in there a bit longer was helpin him with that cos of the shakes he had, like making him a cup of tea cos by the time he got it there it was half drank. Well that's what they do in them RADAR places, they do help each other, the others that are in there, they help the new ones and that's why you went back that time didn't ya cos ya know.* (male participant)

Some participants were negative about sharing facilities with those who were detoxing from drugs. They felt that the group therapy was not as effective as it could have been because of the different experiences with some expressing a preference for alcohol specific groups with a focus on recovery strategies. A few service users described some tension between the two groups. This tension was also reflected through those who were undergoing drug detox being given their medication first which made those in the RADAR unit feel like they were of secondary importance because their length of stay was shorter:

The only, the other thing I didn't like about it, when, if you're with RADAR, I felt you were treated a little bit differently from the people who were in there a long time because they got their meds first and we had to wait. (female participant)

They said well its part of your recovery, no its up to me if a want to go to them thank ye very much, it's not up to you and I didn't want to go, fair enough yer put something on about alcohol I 'll go an y'know, e are I know what alcohol doing to me, am not interested in what heroin or anything like that does to me, cos am not usin em. (male participant)

I would have enjoyed more input on recovery strategies not merely personal accounts. (male participant)

Safe Haven

Of significant importance to service users was the sense of security and safety they felt within the RADAR ward. For many, RADAR was perceived to be a *'safe haven'* or a '*protective bubble'*. This was a consequence of the rapport that participants developed with staff, other service users and the overall environment of the unit. According to participants, the safe environment of RADAR and the peer support meant that they were able to address some of issues that they had struggled with as a result of their addiction such as isolation and insecurity. This perceived sense of security also meant that some service users were *"scared of coming out because I'd been protected for so – you know for that seven days" (female participant).*

The best thing about RADAR it was, I know it sounds a bit OTT but it was like a safe haven for about 7 days, I'm sorry it was 7 day yeah, it was a safe haven and that to an alcoholic is a massive thing. (male participant)

Ya know not being , cos when ya drink ya isolate yourself which unfortunately is not good but at RADAR at least ya know, you were in the care of professionals and you were mixing with other people who unfortunately have got an alcohol or narcotic addiction so it's a safe haven so to speak, yeah. (male participant)

..at that time the way I was feeling I think I would like to have stayed a bit longer a didn't feel ready to come home maybe it was because it was somewhere comfortable to be an a safe surrounding (female participant)

I have felt safe and secure from being frightened coming in, I now feel I don't want to leave, this is a credit to the level of care the staff provide (male participant)

Security

Participants expressed mixed opinions about the security of the unit and the policy towards day release. Some felt the security was not strict enough whilst others suggested that it helped contribute to their feelings of safety, particularly around checking that no alcohol was bought onto the unit. A minority of participants did question the day release policy as they it created opportunities for the patients to consume alcohol:

Yeah, everybody got searched I think, I think that's right, you know, 'cause it puts other people at risk as well. (male participant)

Yeah, yeah because it's obviously for a reason isn't it. I know a trigger for some people is just smelling it on somebody else, so you know it's not, it's supposed to be a safe environments isn't it so I think that's right. (male participant)

He could've bought a bottle vodka in my room, but they'd have known I drunk it with me blood test but that was very easy and the thing I didn't like about it in RADAR there was one lady, she was obviously a drug user, I didn't, I found, I don't know, I found I was a bit frightened of her, she got thrown out cos she was smoking pot, how did they get it in? That's what I didn't like, there's not enough security. (female participant)

Cos you have what you're given there, ya don't just nip to Tesco. But for being an alcohol detoxification centre why are you allowed out to Tesco cos for somebody who desperately wants that drink, you don't wanna be there cos ya were sent by their worker, they want a drink, they're off. (female participant)

Rules and Regulations

Participants also described some issues with the rules and procedures that were implemented in the unit. The nightly checks which interrupted sleep, the inability to go out and the restrictions placed on mobile phones and use of the television were a few of the programmatic issues that service users did not like.

Being checked upon while trying to sleep, having to be let out to go for run, shop etc. (male participant)

Disliked them coming an checking on yer in the middle of the, they used to round every, that used to frighten me to death that. (male participant)

A still couldn't figure out, understand why ye couldn't answer a phone inside and a couldn't figure that one out when you can do that in the bloody hospital. (male participant)

Another aspect of RADAR that service users disliked was the lack of things to do whilst they were on the ward, in particular at night and the weekend. A gap in the provision of leisure and recreation opportunities was highlighted. The need for a games / entertainment room with access to books and Sky TV or a gym was cited as a way to combat the *'boredom'* that some experienced.

Activities to do when boredom sets in. (male participant)

Think it would be better if there was more entertainment. (male participant)

All I can think of is that there is no kind of games room. (male participant)

Aftercare

Many respondents were complimentary of the aftercare provided by RADAR and considered the personalised approach and efficiency a strength of the programme. They recognised the importance of an exit plan in remaining abstinent and were impressed that appointments had been arranged on their behalf upon discharge.

> *There was a lot of after… you know an eye towards after care and stuff like that and alternative therapies… and things like that. It wasn't – it didn't seem it was just a case of detoxing and getting you out the door, you know? (male participant)*

> *Very crucial, the aftercare is crucial ya know I have to say to ya someone coming and giving ya your drugs that's the easy bit, it's keeping off it after It ,cos you still get your withdrawals, ya know you're still sat in the same life, well you think you are. (female participant)*

> *Yeah, they were excellent in setting up … like a plan for when we came out… and they were really good and for some people that was in there they sorted out social problems for the or at least put them, pointed them in the right direction. (male participant)*

Some participants however, did feel that aftercare and support could be improved. This sentiment was reiterated by some of the service providers as well. Service users were of the opinion that more follow up was needed, as they often struggled to remain abstinent once they left the safe environment of RADAR and were faced with the issues that had previously contributed to their addiction to alcohol:

> *It's a good thing, I would think that er they need to do a little bit more, it was one phone call and then no contact afterwards, it would have been nice to a bit more er what can I say, not motivation, I know it's not their job to continue afterwards, it's other agencies, but some sort, bit more of, a bit more of a follow up. (male participant)*

> *..but where RADAR fell down for me dreadfully … was whilst in there it was like this protective blanket, some people refer to it as a bubble.. then I came home and there was nothing. There's no… there was nobody rang me immediately in the… the… the… the time after leaving RADAR, nobody rang me to see how I was going on, nobody came to see me. It was almost as though 'Right, we've done what we can do. Now it's up to you. (male participant)*

The follow up phones once discharged from the programme were generally appreciated and for some, an integral component of the recovery process. A few participants could not remember receiving any follow up phone calls.

> *Yeah it did actually at least it showed that you were ya know, how can I put it, you weren't just a tick box at least ya were in the system. (male participant)*

> *They rang again 3 or 4 weeks later and then they rang again, maybe a couple of months after… Yeah they have to, some people were saying oh I felt like they were checking up on me so, but no I didn't, to me that was part of the recovery. (male participant)*

…I felt er, that it was, yeah they're checking you're okay but whether people like to admit it or not, that's what ya need. I felt it was er, part of a service. (male participant)

Opinion was mixed regarding the Recovery Group on Saturdays for outpatients. Some service users were very positive about the group, so much so that a few have set up a second Recovery Group on Tuesday nights which is more socially oriented.

I tell you what we do on a Saturday when we go round there we have a cup of tea afterwards after the meeting, the look on the nurses face when they see they recognise you and they see you coming back fine that's a great feeling. (male participant)

It's like an extension of the Saturday group… Its', it's a lot more laid back, it's a lot more informal but if anyone wants to get anything of their chest they can do… we go out socially and we arrange nights out. (male participant)

A few did not like the Recovery Group and many expressed an interest in attending but cited the distance to the Chapman-Barker unit as the main barrier to participation.

It's way, way too far away. It's not even I couldn't have got on bus, no I don't know and ya know it was quite a few hours in the afternoon ya know, no. (female participant)

"People want to go back to the Saturday group but it's just too far... actually I should go back to that again but it's just a bit of a distance you know. I felt like I was giving something back a little bit, you know so that was really positive. (male participant)

Volunteering and Peer to Peer Support

Participants were extremely positive about the possibility of volunteering on the unit. This opportunity was seen as a means of helping others as well as helping themselves to maintain their abstinence. Service providers supported the volunteer scheme and considered it to be a key component to the success of RADAR.

But yeah, I thought it was great. It really helped me, like I say you get a small minority that – but you're never going to win in that situation with them. I'm, I'm not just saying that 'cause I've started volunteering … it, it put me on the right track. (male participant)

Personally I need, I think I need to keep working with other people who've er, who need the support an help that I've had. (male participant)

I think [volunteers] are invaluable. You get a lot of patients who come through and they have got that fear factor and the medicalisation of things you know or people who have been sort of cruel in the past and so getting that support from somebody

who got 1-1 knowledge and has been through the process here, that's invaluable to a patient more than anything else. Because if someone's been there and done that and got the t shirt, I think that's a gold standard rather than someone who is just saying 'well this could happen this could happen', and they have not got actual 1-1 experience with it. (Service Provider P5)

Sometimes they find it difficult to speak to the nurses if they have been through that process…it makes them more comfortable I think, 'oh he's done that mine is nothing different so if he can do it I can do it', it's kind of supporting really. (Service Provider P3)

I think it is beneficial across addiction services. You will hear a lot of people say 'oh well you have just been to University and read lots of books, what do you know about it? Cos you've not been there you've not been an 'alchy' or whatever. (Service Provider P2)

RADAR Staff

In general, respondents were highly complementary of RADAR staff, describing them as supportive, friendly, caring, and empathetic. The staff at RADAR provided much needed help and support to address their alcohol dependency. They were considered to be dedicated and knowledgeable professionals. The willingness of staff to listen '*without prejudice*' was very much appreciated and the fact that some staff had previous experience of alcohol dependence and thus could relate to the service users was considered a strength of the programme. Service users felt they were well treated and cared for by the RADAR staff which was critical to the success of their experience. Of particular importance was the dignity and respect that RADAR staff accorded service users.

Because they had an understanding of what… what … alcohol, alcohol addiction, whatever you want to call it or whatever the addiction was they, they had an understanding of it wasn't always as simple as right you know, people having a total control in it, and deciding to do it themselves and that's what they want to do it, it kind of goes beyond that point, so they had that understanding. Plus... I felt that we were directed in a way through it as in you know, we were kind of guided to see that there was a way beyond this, you know, rather than this being the reality, you know. (male participant)

I would not be able to get off the alcohol if it weren't for the people in here e.g. nurses, professionals. (male participant)

I have been treated with dignity and respect and upmost as a human being. Not as a waste of space. (male participant)

Staff have been superb, professional and thorough. (male participant)

The staff here are faultless, helped me see how I can change my life. More than helpful and a credit to the NHS. (male participant)

Willingness of staff to listen, especially those staff who have had addiction problems in the past. (male participant)

Perceived Impact

Attending the RADAR programme had considerable impact on service users. For some, RADAR was perceived as life-saving and for others, it was life changing. A few survey respondents credit the RADAR programme with '***getting them sober'*** and '***curing'*** them. RADAR made service users '***think differently' by*** providing new strategies, tools and opportunities to facilitate sustainable long term behaviour change. Moreover, it instilled many with a sense of hope for the future. A few even credited RADAR with helping them to establish better family relationships and improved health.

> *That's the reason I decided to let you come to interview me because I found the whole experience really helpful, loved it, I come out, I couldn't say, I just loved everything about it, I loved the food, I loved the nurses, I loved everythin, I loved the people who was in there as well with the same problem as me, that helped me a lot, it was fantastic. (female participant)*

> *… you know they were willing to ring my family for me because they weren't really speaking to me cos of my drinking, you know, cos like it was getting worse kinda thing, erm, but they intervened they intervened on that one as well, you know. (female participant)*

> *…got to that Radar Unit and I thought XXXX hell what's this gonna be like got there swear to god I would of stayed there for at least a couple of month, I was actually gutted I had to leave cos they were just none of that about drugs this and that , it was dead nice we had clean it was really treated you well. (male participant)*

> *Because it saves your life , the problem is not everybody gonna get it cos I know in the mind how it works I've seen them there but if it saves two out of ten it stops them drinking it's gotta be good. (male participant)*

> *Well I'd say it was excellent, very committed and er very understanding and real experts in drug rehabilitation, I mean I'd of said that without that the system they had before we you simply went to Accident and Emergency got put on a detox drug ,er and that just doesn't work without further backup and long term . I mean you can't go in and just be kept on er on those drugs for a few days and just go back go back into the world you just gonna end up back where you started. Which is far more expensive than getting people off it in the first place really, so I'd of said its absolutely essential.(male participant)*

> *From inception to discharge I have received and gained absolute positivity from both staff and others like myself. The whole experience has inspired me to attain my goals for the future. (male participant)*

> *It has given me the time to reflect on my past, present also speaking to professionals has given me time to sort my head out and find a way to put things in place with help away from here. (male participant)*

Whilst many service users do lapse after being discharged from RADAR, some felt that the programme was a 'catalyst' for change. Some reported differences in drinking behaviour and the majority have not needed to access A&E for alcohol-related issues since their discharge.

> *yeh but, a think the thing is, it was the catalyst really, Radar unit was the catalyst to things and the an that's puts you in the direction, that suits yourself, for me it was AA have found since for other people, AA's, the don't find it right…. (male participant)*

> *But that's all , no more I've never gone back to drinking any spirits or any er or any drinking any time during any other time but late at night. (male participant)*

6 Stakeholder Consultation

Purpose of RADAR

All participants were clear on the aims and purpose of the RADAR service. These fell into five broad categories.

1. Rapid access to detox services

Most participants stated the key aim of the service was the rapid referral and the expedited process for service users to access detox services. Many participants talked about how important it was to have a detox service available, one with instant access which people were able to engage with when they felt motivated and ready. For those that are at crisis point or have been admitted to hospital this can be a catalyst to encourage them to accept help and services; a rapid referral pathway catches people at this point when they most need it.

> *I would say it is what it is on the tin really rapid access to detox. (Service Provider P1)*

> *I think you know we are unique there isn't anything else…like this in the country but I think there should be…most definitely should be. We've tapped into something that every city could do with…It's instant access, that instant access at moment of need and offering that hope is the difference and I think there is room for both pathways, some people need time to, it's not right for everybody, …and that's why we are all unique human beings aren't we – we all need different approaches. (Service Provide P8)*

Participants discussed that many patients who are in hospitals and withdrawing feel very motivated and ready to detox, however before RADAR they would have had to go home, continue drinking and be seen by a community alcohol service later that week (if not later). Stakeholders talked about how often this motivation was gone by then and the opportunity was lost.

> *…with RADAR it is obviously receive acute admission from the general hospital to reduce the pressures from the hospital beds that's my understanding and I think it is working because in hospital they just keep patients over night give them Librium and send them home. But these people are admitted again but then with RADAR they have got this option of coming here that reduces the readmissions to the hospital and the pressures on the bed. (Service Provider P3)*

2. Reduce the number of hospital beds being used by this client group

The second purpose of the service which was discussed by most stakeholders was how RADAR relieved pressure on hospital beds and enabled people to be treated in the community rather than detox in hospital. Stakeholders reported that hospitals have different polices regarding detox, with some discharging people as soon as they were 'medically well'. Some hospitals will prescribe detox medication and manage this on the ward. However, all participants agreed hospital was not the ideal place for this client group to stay or detox. The RADAR service reduces the number of patients in hospital by ensuring service users can move to a non-acute detox facility quickly; often on the day of their admittance to A&E.

…to reduce stays in the acute hospitals of patients who are alcohol dependant…to get people involved with alcohol services and to assist us in reducing the frequent flyer attendances. (Service Provider P4)

…it is basically to reduce acute admissions to acute trusts, to prevent beds being utilised community services can basically be involved with rather than keeping patients in for a detox because it would have been a chemical detox solely and there's no rehab therapy available within the acute trust. (Service Provider P5)

3. Additional social support and exit plan

The majority of stakeholders felt one of the main aims of the RADAR service was to offer additional social, emotional and psychological support and address practical support concerns. Whilst on the RADAR unit clients are offered holistic treatment for mental health issues and are also able to access a variety of support groups and psychological support. Many stakeholders pointed out that detoxing was not just about physical symptoms but clients also needed support to address mental health issues as well. Moreover, service users are able to work with social workers and community services to address any practical problems like insecure housing or financial issues during their stay.

Before [RADAR] they would have just been rocked up to A&E and given a bit of a rough time and not specific you know what I mean there's no specific service for them and then bobbed back out into the world - revolving hamster wheel again. (Service Provider P2)

…for me it's first it's about causal factors rather than just treating the symptom of the cause. Do you know what I mean? (Service Provider P2)

All clients leave RADAR with an exit plan and are also then supported by community alcohol teams. This planning for the future aims to help recovery and reduce chances of relapse by treating psychosocial, not just physical symptoms of alcohol addiction.

4. Reduce the number of repeat A&E attendances

A minority of participants felt that rapid referral to detox services reduced the number of repeat A&E attendances and repeat hospital admissions (often referred to as 'frequent flyers'). This small number of high risk individuals often present regularly in A&E and having a rapid referral to detox service enables them to access a detox service when they most need it.

5. Target a client group that would otherwise not access detox services

Two stakeholders suggested that one of the aims of RADAR was the reach 'functioning drinkers', not just dependent and long term drinkers. They felt that there is a group of drinkers who are not accessing traditional alcohol services, who need detox and support but would not normally access alcohol services. By accepting referrals directly from acute services, RADAR picks up these people who would not otherwise present at alcohol services.

For me it's very much about identifying a group of people who wouldn't, otherwise, access services, they wouldn't see themselves as needing traditional alcohol services but by using health services… that group of people…are presenting regularly but wouldn't necessarily think that they need to seek help elsewhere. So we're offering them that input and I think that's been the kind of light bulb moment for a lot of people 'I've never considered myself' and that. So that was one of the main focus of people we wanted and the other one is the frequent flyers as they get called. (Service Provider P8)

Achieving RADAR's Aims and Objectives

Overwhelmingly, all stakeholders were of the opinion that RADAR was achieving its aims and objectives. Although not all clients stayed sober or recovered quickly, interviewees felt a large proportion of clients were in recovery and that RADAR played a significant role in this sustained sobriety. Some felt the success of the project was demonstrated by the number of clients who had been through detox and now attended the Saturday support group or who now volunteer for the service.

It was suggested that those who do not succeed in staying sober are often those with underlying mental health conditions. For those service users who are in the 'right place', using the RADAR service has a strong positive impact on their recovery, evidenced by good rates of abstinence post RADAR as well as service users continued attendance at RADAR's Saturday support group.

Sometimes it is necessary and appropriate to discharge a patient to drink but there are people who you know are motivated and want to get involved with services it's great for us an , it's great for the patient that we have got that offer available to them. (Service Provider P4)

I mean, the group on a Saturday for example is very much ex former RADAR patients…which speaks for itself, the fact they're still coming back. And the amount of people who want to be volunteers and they do, it's amazing really. It really is amazing, it speaks for itself, it really does, it works, it works. (Service Provider P6)

We follow up with our patients, every patient that we see or send to RADAR we will follow up on four weeks later to see how they are getting on, see if they have engaged with the service see if they have stayed on RADAR some will have self-discharged. Over the last couple of years there has been about 50% success rate with our patients who have had a good period of abstinence after having a RADAR detox a good period we say is 3-6 months. (Service Provider P5)

Referral Process

The majority of stakeholders believed that the referral criteria and process were key to the success of RADAR. Choosing the appropriate patients to refer was vitally important, to ensure efficacy and the biggest impact on recovery.

Because there are so little beds available basically so we want to give those who are going to engage fully a chance of recovery basically. If the patients are motivated, there are no medical needs and they tick the boxes we will refer them over to RADAR at that stage …Its experience and intuition it's listening to the patient. (Service Provider P5)

So it's kind of getting the base right really. If we have got the bloods and if they have had any mental health problems if we have got an assessment, it's pretty straight forward and within an hour they should get a decision I would say. The only delay really is a problem with their bloods - they just have to have repeat bloods done and then do it again ...From an hour to like six hours probably and sometimes we have been full and we have asked them to ring next day. (Service Provider P3)

Between the hospitals there were slight differences in which staff could make the referrals; at one hospital is was only alcohol liaison nurses but at another it was alcohol liaison nurses, mental health nurses and a small number of trained doctors. Which staff can refer to RADAR had been worked out over the course of the project and all stakeholders were happy with the system they had in place. One stakeholder discussed how they had changed which health care staff could refer from their hospital, to minimise inappropriate referrals.

So for our hospital anybody that we get referred to RADAR goes through the alcohol team, there has in the past been occasions were A&E staff have referred but their referrals have turned out to be inappropriate, all the documentation hasn't been completed...So we have agreed that the alcohol team would just refer patients however we have discussed that with like the psychiatric liaison service, we may start training their staff to do the referrals. (Service Provider P4)

Originally we let the mental health liaison team refer in but they were using it as a quick fix really so we took that privilege off them...so it has been a bit hit and miss you know we have had to reign it in slightly...Yes we have had people knocked back...probably about three out of the whole lot. (Service Provider P7)

All stakeholders discussed the importance of referring the 'right' patients to RADAR; stakeholders talked about it needing to be the right time for patients and for them to be motivated. This point was acknowledged by service users as well. One stakeholder mentioned how they avoid referring patients who have used many detox services and travel around trying to access more medication.

I think from the medical point of view, from the Trust a lot of people who didn't understand it, they were trying to send people who didn't warrant going which is why we have nailed it down to only a certain few people are being able to refer in, so we are getting the right sort of patients in there. (Service Provider P7)

You think is this patient just benzo seeking, are they doing the hospital routes, were they travel postcode hopping for benzos and things like that. So it's doing a lot of digging and just taking the overall perception of the patients, do you think this patient is suitable. (Service Provider P5)

In general, stakeholders felt the referral process worked well. The decision to accept a patient on the RADAR ward was quickly and smoothly with very few occasions where RADAR had refused to take a patient; this was usually due to no spare beds or incorrect paperwork. The decision was thought to be quite quick, though it could have been quicker as often patients are waiting in A&E or on a ward for a few hours awaiting a decision. One stakeholder thought the referral process had become slower since RADAR was merged with another unit as staff are busier and it takes longer for them to make a decision.

> *It takes a couple of hours sometimes it is quicker than others, I think it can depend on how busy RADAR is itself. (Service Provider P4)*

Peer to peer support

Generally all stakeholders felt the peer to peer support element of RADAR was very important and successful. The key benefits of the volunteer programme and peer to peer support included;

- clients at RADAR appreciate the first-hand experience of the volunteers,
- volunteers act as role models and show it is possible to recover
- they reduce the fear for some clients by seeing others like them
- clients are able to identify with and relate to peers more easily than staff

> *I think [peer support] is really really good and a lot of my patients that I see relate better to somebody who's been through that process themselves. (Service Provider P7)*

> *...for the patients as well, you know these people are in recovery doing it, living it. We couldn't be without them [volunteers] on the unit and we're very lucky that we've now interviewed some of the volunteers now and they're gonna be coming on the nursing bank, working with us as well, which will be more fantastic for them and for us. (Service Provider P8)*

> *it is also very useful for them to speak to somebody who's been through that process, and they can identify with the volunteers in a different way than they can with the nursing staff because at the end of the day the majority of the nursing staff haven't been through that process so a lot of the patients really like that. (Service Provider P4)*

Some volunteers have now been recruited as support staff and paid members of the team. One stakeholder mentioned some former clients going on to study nursing. This was given as an example of the effectiveness of the volunteering programme and also the success of RADAR in aiding recovery. One stakeholder has a few concerns about the professionalism of volunteers as it is sometimes difficult for them to remain objective and impartial. However this stakeholder felt the benefits for clients outweighed these possible challenges.

Implementation of RADAR

Challenges and barriers

Most stakeholders felt the implementation of RADAR had been very smooth and there were only minor challenges and barriers such as who takes responsibility for transport such issues were easily overcome. Three stakeholders discussed that staffing levels and funding caused some challenges when the service was first being set up. Some hospitals have vacant alcohol liaison nurse positions and being short of staff means the nurses cannot always spend as much time as they would like with patients. One nurse discussed how this pressure means they spend more time working with dependent drinkers and not enough with the heavy/hazardous drinkers as they would like. Turnover of staff was also thought to be problematic as new staff do not always refer appropriate patients.

Several stakeholders felt the RADAR service had been negatively affected by the merger with the other Chapman-Barker ward which was necessitated by a funding shortage. This merge has meant that referrals take longer as there is not always a nurse available at RADAR to discuss referral. From the perspective of the staff at RADAR, the merger has meant that there are now mixed client group (those with substance use addictions) which poses some challenges for both service providers and service users alike. Several service users disliked the mixed group sessions and felt that '*RADAR should have their own groups' (Service User).*

> *Well I think it was more to do with the funding and the staffing really, and I think it has had some impact on RADAR, because initially when it was independent ward we had more input with the clients because we were just focusing it was quite intense …they has lots of one to ones and lots of interaction with staff, they do get it now as well…but we are quite limited because of the numbers it's stretched sometimes. (Service Provider P3)*

> *I know that when RADAR was a unit by itself, it was probably a bit quicker that's because the staff were there just to deal with RADAR patients, but now that RADAR is integrated with the Chapman and Barker unit the staff might be doing a ward round you know the nurse in charge might be doing a ward round you know a medication round. So you know sometimes it takes more phone calls then we would like, we might ring up to find out if there is a bed and then they will ring us back and then we will broach that with the patient. (Service Provider P4)*

> *I had a patient I think it was only last week and he refused RADAR again even though he was eligible for it, because he said it wasn't the staff they were great, the philosophy of it was great. But it was the other patients they were horrific...hahaha last time he went he said there was a guy running around with a knife, I think that would be enough to put anybody off wouldn't it. (Service Provider P5)*

One respondent felt it was vitally important that the RADAR service maintains its identity, separate from the other services within Chapman-Barker unit. They felt some commissioners are unclear on the pathways of the services and it was important for the RADAR pathway to remain distinct.

> *I do think when it was separate, obviously it had a very clear identity and it had a clear staffing that was additional, you know, that worked solely with just those patients and I think it does work as it is now but I think that there's always a danger of it, when*

you've got different pathways but they can be very similar, cause once the person arrives here, they're coming in for an addiction problem for alcohol as our other patients so there is a very similarity which has been good really...cause obviously, they're in the same therapy groups together but I think we've got to, you know, that identity of why RADAR, what the purpose of RADAR is has to be kept clear. (Service Provider P8)

One nurse discussed how there was pressure hospitals to move patients out of hospital and vacate beds. This meant there was often the challenge of balancing the demands from the hospital with needing to only refer appropriate patients.

I think it was quite challenging dealing with the other professionals as well because when you say no it's kind of there are Nurses there's Doctors, Matrons, Senior Managers because they have pressure for the bed putting pressure on us you know you need to take this. (Service Provider P3)

Successful elements of implementation

Stakeholders felt many of the challenges in setting up RADAR were overcome with good communication, clear processes and amending and updating the paperwork and forms. Stakeholders felt there were good working relationships between staff at RADAR and within hospitals and community alcohol services. Some stakeholders mentioned they felt the good communication meant they felt they could feedback any issues or concerns with the system and commented that some processes had been amended as a result of their feedback. The presentations from RADAR staff to hospital staff during implementation were also commended. Two stakeholders who work within hospitals talked positively about having been able to visit the RADAR unit as this enabled them to explain it in detail to the patients they were referring. They thought this helped relieve patients fears.

No I just think that it was communicated really well we were given the contact details for the staff , we ended up going as well but then as a team we went to RADAR to have a look around...We met with the ward manager that was an opportunity...When you are referring a patient it's really good to be able to describe exactly what it's like. (Service Provider P4)

Impact of RADAR on Service Users

Overall stakeholders felt the RADAR service had a significant positive impact on service users. The element that was thought to have the biggest impact was the additional psychosocial support and exit planning. This was thought to address issues and support service users in a way that other detox services did not; RADAR is not just a chemical detox programme but a more holistic service. The one-to-one support was thought important as it allowed service users to address mental health and social care needs, as well as the symptoms of alcoholism.

I think it gives them the best chance of sobriety rather than a hospital detox because…they are there fully and that's what they are there for to concentrate on the detox. They have the social worker who I know is about and they can link them in with

a community nurse who goes and visits them while they're there and I think it gives them the best chance really. (Service Provider P7)

Two stakeholders discussed how the RADAR service had been effective as it was enabling hospitals to free beds and was reducing the number of readmissions. However one alcohol liaison nurse suggested they could not always see the impact on readmissions as they rarely referred 'frequent flyers' to RADAR; therefore it was not as obvious when they did not return.

For A&E services and for our services in particular, as awful as it sounds it's getting bums off beds and that is our job within the NHS to get bums off beds and to make sure they are getting sign-posted to the correct services rather than utilising A&E beds. (Service Provider P5)

Two nurses based in hospitals felt that although RADAR had a positive impact this was not always easy for them to see- and they would like more feedback on the patients they refer to RADAR. If they had more feedback they would be able to better understand the efficacy of the service.

We don't really get any feedback afterwards unless they do re-attend [hospital] and it's quite often mainly regular attenders who do come back that I probably wouldn't send them in the first place. (Service Provider P1)

I think really positive, I think it works, it makes a difference to a lot of people, yeah…We have had some people come back for the second time with us but what we always say is 'what did you learn from the first one as it may be this time you do it' so yes I think its been good.(Service Provider P8)

One stakeholder discussed how they felt RADAR was very effective for new clients who had never been through detox before. It was thought to have a bigger impact on these treatment naive patients compared to patients who had been through detox before or who had been receiving treatment for a long time.

the impact I think for people who have never had a detox…never touched treatment services of which there has been several, I think it has been huge because it has actually been that sort of pivotal point, that light bulb moment actually I need to get a track of my life and this is my opportunity to do it (P2)

However two stakeholders also suggested that although it was not as effective for patients who had been in treatment for a long time, it was part of a process and even patients who attend RADAR more than once learn from the experience and it is part of their journey to recovery.

It does help a client in their recovery …and having all this support throughout the recovery helps the client to stay …and to identify what the issues are because I think that's is what they do…identify what the triggers are and work on the triggers. Which is the main thing probably because anyone with alcohol problem there are always some triggers? (Service Provider P3)

Service users think it's really positive, it's giving them the opportunity of immediacy, the action of actually making changes when they are ready to make it's that swiftness of it. It starts to come across in patients who I have met who have done RADAR and have maintained abstinence and stuff and basically it's a life saver. For those who have

then relapsed with their drinking again it's something they know is out there and can be accessed if and when they are ready to make the changes. (Service Provider P5)

Added Value and Unique Elements of RADAR

All stakeholders believed the RADAR was unique in the service that it offered and stakeholders were not aware of any similar services anywhere else in the UK. There were two main reasons the service was thought to be unique – and these are two themes that were discussed multiple times in the stakeholder interviews – immediacy of referral and the additional psychosocial support during detox.

The waiting time you know is one of the biggest … to be able to say to a patient that you can get then into a …specialised detox unit straight from coming into an acute hospital is really useful. [with a detox in hospital] they are not getting the same physiological input that they would get at the Chapman and Barker unit ....You know they are getting the group work there, they are getting support from the volunteers from other patients who are in the same situation as them. (Service Provider P4)

The instant referral for detox was thought to be the key factor that made the service unique and increased the impact. The speed with which a patient could be transferred from hospital to detox service is unique to RADAR. Other community alcohol and detox services in Greater Manchester were said to have a waiting list of 4-6 weeks; and within this waiting time a patient can lose motivation or circumstances can escalate. The instant referral was thought to increase success of the detox because it offers treatment to people when they are very motivated to recover, and it also stops things getting worse and averts a crisis.

[Without RADAR] they might of rocked up in A&E they might have gone on a medical ward they might of got a bit of lithium and….then might have been discharged part way through a detox. And then they would come to us [community alcohol team] and say 'can we have it [detox]?', 'no you can't'. And they go to the GP and the GP says 'no you can't have it' so they start drinking again. (Service Provider P2)

The second important factor that was thought to make RADAR unique and very effective was the whole package of care that supports the chemical detox process. The group support, social worker input and mental health support enable the client at RADAR to personally tailor what is needed for their recovery. This holistic care enabled clients to address the underlying causes of their problems not just treat the physical symptoms of their addiction.

Two stakeholders talked about how if they were not able to refer patients to RADAR they would have to instruct them to go home, keep drinking alcohol and then refer them to the community alcohol teams. Both discussed how unsatisfied they were giving advice to keep drinking and they felt patients were unlikely to engage with alcohol services a few weeks later. This felt like a missed

opportunity for an intervention. Two stakeholders also talked about their concern about what will happen to these patients if funding is cut for RADAR.

> *So if I think someone is in danger…they're hallucinating in A&E you know I would tell them they have got to go home and continue to drink and I will refer them onto an appropriate service. So there isn't anywhere really where I think I could refer them on for or something like that, so [RADAR] is a unique service. (Service Provider P1)*

Stakeholders who were based in hospitals talked about different hospital trust policies about doing detox in hospital. Some hospitals will prescribe detox medication and a patient can stay as an inpatient whilst they detox, however this does not include any additional psychosocial support. Other hospitals have a policy not to keep patients in just to detox so would discharge patients. Without RADAR the outcomes for both sets of patients were thought not to be as effective as a referral to RADAR.

Two stakeholder also discussed how RADAR is unique in that it attracts a client group that never use community alcohol teams; this group is often employed, were seen as 'high functioning' and would not be seen in any other service. However due to the referral processes from A&E they are picked up and referred into RADAR.

> *Because it's that emergency when somebody comes into A&E and they want to stop drinking and they have turned to the NHS to support them and there is nothing there for them, you know we can't offer them a detox [in hospital]. [Without RADAR] the acute trust would say 'well you have got to go home and drink and wait for community services'. It's very disheartening for the patients (Service Provider P5)*

> *If they take away RADAR this is not going to happen and remember you're not going to catch on that population is not going to any alcohol team, staying at home in their comfort zone, we have had ladies 80 years old and 75 on RADAR believe it or not. (Service Provider P3)*

Suggested Improvements

A number of suggestions were made about how to improve the RADAR service. Three stakeholders (nurses based in hospitals) suggested it would be helpful if they could receive a quicker response from RADAR on whether the ward was able to accept a patient they wanted to refer. This could sometimes take a few hours of phone calls and passing information back and forth before a decision was made. The staff at RADAR were thought to try their best but they were busy and not able to confirm place as quickly as the hospital needed to enable beds to be available to other patients.

> *I don't know how long it should take but I can wait sort of like a few hours and bearing in mind you have got someone that's at risk of seizures who is dependant, and obviously they are taking a bed up and the pressure is on you to try to clear the bed because you have got the ward saying I thought they were going… I'm just waiting. And because you know I'm round the hospital with the bleep I'm like just waiting, then*

you feel like you're harassing them, did you make your decision yet? (Service Provider P1)

It was noted this delay had increased since RADAR had merged with the other unit at Chapman-Barker. One stakeholder discussed pressure from the matron in their hospital to move patients on and free bed space and how the delay from RADAR can cause tension. It was suggested that such delays could be alleviated with an additional member of staff added to the RADAR team. Specifically it was suggested that a nurse who had responsibility for liaising with hospitals about referrals and who had capacity to keep hospitals updated on the number of spare beds in the unit was required.

I think RADAR needs to be one ward but obviously it's not going to happen I think each individual ward as RADAR not saying it's not better now but it was more better when it was RADAR single ward we could focus more on clients it was more intense and it is effective now as well but it could be made more effective and if we want more but the pressure on the staff and the funding it's not going to happen. (Service Provider P3)

I think it's important to have somebody who can [to alcohol liaison nurses] say is everything ok? and is there anything that we can be doing to support you and the opposite when we are full look we are quite full at the moment just wanted to give you a heads up if you are seeing people this is how we can work. We don't ever want to say no if somebody rings us up as we have only got so many beds as well. So I think that would just make the service better. (Service Provider P8)

Many of the suggestions about improvements related to capacity and funding. Stakeholders were concerned about the future of RADAR if further funding was not secured. Another stakeholder thought RADAR would be improved if it were to return to a separate ward. One stakeholder suggested increasing the number of beds on the RADAR unit would enable them to refer more patients, currently they felt they had to prioritise patients and only refer the patients who were most likely to benefit. If there were more beds they would refer more patients.

Two stakeholders (both nurses who refer patients to RADAR) suggested they would like more feedback on the patients they refer. Because they usually refer patients they only see once in A&E they do not know if the patients are in recovery or if they just have not returned to A&E. They believed it was easier to see the impact on patients who regularly attend A&E but they were unlikely to refer these patients.

we did say at that last meeting it would be good to get feedback on the patients that we sent there, so they said they would send us a copy of the discharge summary that they send to the GP's but it hasn't happened…I mean we don't actively look for the patients that haven't but we know like the patients that have come back in to A&E that we know we have sent to RADAR then we would discuss that with them. (Service Provider P4)

One stakeholder suggested there needed to be a simpler pathway into community alcohol services from RADAR. They felt that sometimes they were only notified of patients on day four or five of their detox, just before they were discharged. They would like the community alcohol team to be involved earlier in the process so they get to know the patient and can support them more easily when they are discharged.

> *So when I have chased patients up four weeks later sometimes community services have not yet engaged with these patients and captured them and I find that quite disheartening…If we could then say within 2-3 days how you are getting on how is it at home? And stuff like that 2-3 days afterwards rather than 2-3 weeks later when people just feel like they have been dropped into the abyss again and there is not that follow up support again, I think it is something that really really could be improved upon. But again that is individual to each patients postcode it's like a postcode lottery. (Service Provider P5)*

In line with several service users, a few of the service providers felt that support after discharge could be improved. In their opinion, some patients drop out of services and more work needs to be done to keep them involved with community alcohol services. One participant at RADAR felt that more could be done to inform clients about what support was available on discharge, especially in other areas. If a client moves to another local authority soon after discharge they will not know about what services are available.

> *We have had phone calls 'this person has been discharged [from RADAR] today' not acceptable you know. We had erm the referral should come from the staff at RADAR it wasn't happening … Now with staff changes agency staff I think there must be some difficulties getting staff to understand the process we have had a pathway drafted up which was quite simple to follow but it wasn't being followed, so we do now go in and take our own referrals. (Service Provider P2)*

7 Cost-effectiveness Analysis

The cost-effectiveness analysis of RADAR is based on the collation of several sources of information: the costs of delivering RADAR during its first two years of operation and information gathered from a telephone survey carried out by the Centre for Public Health.

RADAR Occupancy Data

A key issue when examining the costs associated with RADAR is the occupancy rate of its beds. Many costs are fixed, so that, for example, the costs of treating only one patient (expressed as a cost per patient) will be much higher than if all available beds were occupied. This is especially the case for data from the first year of operation, as when the referral pathway was being rolled out across the Greater Manchester A&E departments, there would be times, particularly around the opening of the ward, where occupancy was comparatively low. Across the two years there were 636 patients, and the average length of stay in RADAR was 6.5 nights (falling between the planned five to seven nights). These 636 patients accounted for a total of approximately 4,134 bed-nights (out of a total possible bed-nights of 7,300 for the ten bed ward) giving an average occupancy of 57%.

RADAR Cost Data

Actual cost data of running RADAR in the first year were supplied; this comes to £884,315. RADAR has also supplied a 'tariff' for a bed-night within the service. This tariff was suggested to be £276 and this is the 'per-patient' tariff that can be used when estimating the on-going costs of RADAR. We can apply the bed-night tariff to the ideal occupancy scenario to calculate a cost of £805,478 for running RADAR in a typical (i.e. not the first) year.

Benefit Estimates

This report includes two main groups of benefit that can be attributed to RADAR; the costs saved by admitting the patient into RADAR instead of a general hospital admission (expressed as saving in general hospital bed nights), and the more long term savings to health and social care services that can be attributed to the patient's change in behaviour after receiving the detox at RADAR.

Benefits Realised by Avoiding General Hospital Admission

An internal evaluation carried out by RADAR examined the likely number of bed-nights in general hospital saved by admitting patients into the RADAR ward. This was done by examining the data on the 339 patients in the first year and looking at when they were admitted into RADAR and comparing the number of bed-nights the patients had in general hospital with the number of bed-nights an average alcohol-related admission would usually require. The following section focuses on the savings achieved by avoiding general hospital admission, using data that were collected for the first year that RADAR was open.

The average length of an alcohol-related hospital admission was taken to be 2.2 days, at a cost of £1,667 per admission. This converts to a bed-night cost of £758. The cost was derived from a 2010 National Institute for Health and Care Excellence document on alcohol use disorders NIHCE (2010)[6] updated to 2012/13 to account for inflation[7] whereas the average length of an alcohol-related admission comes from local data.

For the 339 first year patients, 22% were admitted directly into RADAR, bypassing admission to general hospital. For these patients, it can be assumed that they each saved the £1,667 average alcohol related admission cost, which would come to a total of £124,325.

For those who were admitted to a general hospital, but did not stay overnight, there would still be the savings in bed-nights. 33% of the first year clients were transferred the same day (again saving £1,667 per admission) which totals a saving of £186,487.

There were some patients who, while having one bed-night in general hospital, would still provide a saving as their admission was still less than that of the average alcohol-related admission. 24% of the first year patients had a one-night stay in general hospital prior to admission to RADAR. Proportionately, since they had one night compared to the 2.2 night average admission, the cost saved by admission to RADAR by avoiding a general hospital admission would be 1.2/2.2 = 54.5% of £1,667 or £909.27 per patient, or £73,978 in total.

Therefore by admitting patients into RADAR and either avoiding general hospital bed-nights completely, or reducing the number of bed-nights, the 339 first year patients saved general hospital bed night costs of £384,791.

As previously noted, we can also model the scenario where a ten bed RADAR ward operates at an ideal occupancy of 80% (456 patients per year).The cost saved to general hospitals due to admitting patients into RADAR at the ideal occupancy is £517,594.

Benefits Realised by Patients' Behaviour Change

Information was provided by a hospital, reporting A&E attendances and hospital admissions (both in terms of the number of admissions and the number of bed nights) in the three months pre-admission and the three months post-discharge. Although data from an internal survey of 86 patients was available, the data was not used within this analysis.

Telephone Survey Data

When LJMU started the external component of the evaluation, data on A&E attendances and hospital admissions by RADAR patients were provided. In addition to these data, LJMU also collected data that could be used to estimate other health care, criminal justice or social care costs. The LJMU data collection was based on a telephone survey of RADAR patients, asking them about their use of

[6] National Institute for Health and Care Excellence (2010) Alcohol use disorders: preventing harmful drinking costing report.

[7] Provided by the Department of Health, 2013. The methodology for the pay cost index was revised in 2011/12 and now uses Electronic Staff Record data at occupation code level. Pay cost data are therefore not comparable with earlier years. The 2012/13 pay inflator has been estimated using the average of the three previous years.

various health and social care services in the six months prior to their RADAR admission and the six months following their discharge from RADAR. We are using the information supplied by 98 out of the 636 patients (15%), most of whom were first year patients. It should be noted that the 15% of first year patients included in the telephone survey does not equate to a 15% response rate; only the patients who had given consent to be contacted and had provided contact details were included in the telephone survey. In a substantial number of cases the telephone number provided was no longer valid, sometimes the number was not answered after five attempts at calling, and in some cases the patient had died following discharge from RADAR. It should also be noted that a small number of individuals had been patients of RADAR more than once (although for the purposes of the analyses presented in this report multiple admissions are treated as separate cases). Because the survey asked about the six months after discharge from RADAR, only patients discharged within the first 18 months were eligible for a telephone survey.

Accident & Emergency

Data from a telephone survey of 98 patients covering a six-month period were used to estimate the benefits realised in a reduction (or increase) in A&E attendances. The following approach was used to calculate the benefits realised:

- Sum the number of attendances in the period before RADAR
- Sum the number of attendances in the period after RADAR
- Subtract the 'before' total from the 'after' total
- Divide by the number in the sample (98)
- Therefore calculate the average reduction or increase per patient
- Multiply by the unit costs (listed in Table 1)
- Multiply by the number of patients per year (under the ideal occupancy scenario)
- Extrapolate (where appropriate) from 3 month / 6 months to a 12 month period.

So for example, the 98 patients within the telephone survey, there were a total of 334 A&E attendances prior to RADAR and 57 after RADAR. Using the same approach as above, the 6-months savings for the ideal occupancy scenario would be £72,931.

Hospital Admissions

There are different approaches to estimating the costs due to a reduction (or increase) in hospital admissions. The telephone survey data can be used in two ways: by counting the number of admissions and applying the cost per admission, or by counting the actual number of bed-nights and applying the bed-night costs. By using both approaches, the following savings are estimated for ideal occupancy;

- 3 months (admissions) = £689,440
- 3 months (bed-nights) = £369,763
- 6 months (bed-nights) = £719,512

Outpatient Attendances

The telephone survey included data on outpatient attendances, estimating a saving of £19,473 when the ward operates with the ideal occupancy over six months.

GP Appointments

GP appointments, including home visits, were also included in the telephone survey, with an estimated saving of £24,276 for ideal occupancy over six months.

Other Alcohol Detoxes (not RADAR)

The final health cost included in the telephone survey was for other alcohol detoxes. Again, for the six month period the savings for the ideal occupancy would be £7,629.

Criminal Justice Costs

The telephone survey asked about the patients' contact with criminal justice services (e.g. number of times they have been arrested) before and after RADAR. While the cost-effectiveness analysis outlined in this report is primarily focussed towards health service savings, criminal justice savings when the ward is operating at ideal occupancy are estimated to be £267,071 over a six month period following discharge from RADAR.

At this stage the criminal justice costs are not included in the main analysis; however there is a likely saving of approximately £270K.

Unit Costs

The unit costs used in the analysis are listed in Table 4.1. These have all been updated to be relevant for 2012/13.

Table 4.1: Unit costs

Description	Cost	Notes
A&E attendance	£57	Adapted from Parrot et al[8]
Alcohol-related hospital admission	£1,667	Adapted from NIHCE (2010)
Alcohol-related bed-night	£758	Adapted from NIHCE (2010)
GP surgery appointment	£24	Adapted from Parrot et al
GP home visit	£75	Adapted from Parrot et al
Outpatient attendance	£174	Adapted from Parrot et al
Alcohol detox	£66	Adapted from Parrot et al

[8] Parrot, S., Godfrey, C., Heather, N., Clark, J., & Ryan, T. (2006). Cost and outcome analysis of two alcohol detoxification services. Alcohol & Alcoholism, 41(1), 84–91.

Extrapolation of benefits realised

The data on the benefits realised (i.e. savings in A&E admissions pre- and post- RADAR) relate to either a three-month or six-month period. The savings can be extrapolated to a 12-month period to obtain a likely saving for a whole year. However such an extrapolation assumes that the change of behaviour in the six months following discharge is sustained for the rest of the year.

Table 5.1 Cost-effectiveness summary

Description	**6 months**	**12 month**
	£	£
General bed-nights saved due to RADAR admission	***517,594***	***517,594***
A&E attendances	72,931	145,862
Hospital admissions	719,512	1,439,024
Outpatient attendances	19,473	38,946
GPs	24,276	48,552
Other detox	7,629	15,258
Total	***843,821***	***1,687,642***
TOTAL BENEFITS	**1,361,415**	**2,205,236**
RADAR COST	**884,315**	**884,315**
BENEFIT - COST	**447,100**	**1,320,921**

Table 5.1 presents the estimated savings attributable to RADAR under the ideal occupancy scenario and for both a six-month and a 12-month period, with the 12-month saving assuming that the behaviour changes reported in the six-month period are sustained for a further six months.

As previously noted, the preference in this report is to go with the actual first year costs of RADAR and assume that the ward could have operated at 80% occupancy throughout the whole year. Balancing the costs and benefits of RADAR suggests that RADAR is cost-effective, with health-care related savings (benefit – cost) over a 12-month period of approximately £1.3 million. This assumes that the behaviour changes reported at six months are sustained to 12 months. Consideration of the savings over a six-month period only still suggests health-care related savings of £450K.

8 Discussion and Conclusions

8.1 Qualitative Analyses

Analysis of the qualitative data has demonstrated that the RADAR experience for both service users and service providers was overwhelmingly positive. For service users, the staff and the environment were the main factor that contributed to their experience. They discussed how their experience of RADAR was different to other services that they had used because of the non-judgemental staff and the peer support that was gained through the communal atmosphere. Many of the participants recognised the experiences of some staff in terms of their own recovery and felt that this helped them to relate to them more easily and thus provide a more empathetic service. The set-up of the unit meant that the service users still maintained many of their usual freedoms (such as choosing their meals, seeing visitors) and those rules that were in place were generally seen as a way of contributing further to the safe environment of the unit. Some participants did express a frustration with some of the rules that were implemented (such as restrictions on the television and mobile phones) and felt that these needed to be addressed. Although some service users found the time away from family and friends difficult, others expressed a desire to stay longer. Most stated they would recommend RADAR to others. The 'safe haven' that RADAR successfully provides along with the positive role modelling suggests that RADAR is an effective therapeutic milieu for patients with an addiction to alcohol.

Service providers concurred as they considered RADAR to be a unique and effective detoxification programme, one that successfully achieves its aims and objectives, as measured by the number of attendees at the Saturday Support Group, the number of volunteers in RADAR, the good rates of abstinence post RADAR and the fewer readmissions to A&E. The referral process works well although some providers would appreciate a faster response to referral requests. Appropriate assessment of patients, to ensure they are 'ready' for detoxification was considered key to a successful outcome. Peer to peer support was perceived to be a vital component of RADAR and highly praised. Challenges and barriers were minor and focussed mainly on staffing issues and insecure funding. These were generally addressed by good communication systems, clear processes and amended forms. All stakeholders believed that RADAR was a unique service in the UK, because of the immediacy of referral and the additional psychosocial support during detox. Additionally, RADAR also attracts a client group of 'high functioning' alcoholics that would not be seen in any other service. Overall stakeholders felt the RADAR service had a significant positive impact on service users. The provision of tailored psychosocial support and an exit plan as part of the package makes RADAR a more holistic service; allowing service users to address mental health and social care needs, as well as the symptoms of alcoholism.

Whilst both service users and service providers were overwhelmingly positive about RADAR, some suggestions to improve the overall experience have been made. They include the following:

- Provision of more follow up support in terms of aftercare, to assist with maintaining abstinence

- Set up support groups facilitated by RADAR in other areas of Manchester, to assist with ongoing abstinence and recovery and to address the lack of access to the current outpatient services
- Offer stays longer than 7 days, to help with the transition after completing the detox
- Offer single-client group therapy sessions
- Provide information about the RADAR programme, to ease referral anxiety and reduce stigma associated with the location of the service
- Increase capacity in terms of beds available and staff on the RADAR unit, to expedite the referral process and ensure beds are kept free in the acute setting
- Provide better feedback on patients referred to RADAR
- Expedite the referral process – faster response rates to referral requests

8.2 Cost-effectiveness Analysis

The cost-effectiveness estimates of RADAR are derived from models that employ various assumptions about RADAR patients. This is common to most cost-effectiveness analyses. These assumptions include the appropriateness of attributing all behaviour change to RADAR, on the basis that this is likely to do so for this particular client group. It is thought unlikely that the patient may have just detoxed and reduced the associated healthcare costs irrespective of whether they attended RADAR or not. The information on behaviour change comes from two different samples: one collected as part of the internal monitoring and evaluation of RADAR; with other was independent, based on a telephone survey carried out by LJMU. Both are comparatively small, with the internal sample being based on data from two out of the ten local authorities, although there is no reason to assume that the impact of RADAR would differ significantly across local authorities. The relatively small number of responses for the telephone survey was almost entirely due to the accuracy of the contact details (i.e. many of the mobile phone numbers that were provided on leaving RADAR were no longer valid or just ringing out). There were very few instances where once contact had been made, the RADAR patient declined to participate. While there may be differences between those with valid current phone numbers and those who did not, there does not appear to be an immediate link between levels of alcohol use and contactability via phone. Finally, the sustainability of the impact of RADAR could not be tested and therefore it can only be assumed that the levels of healthcare usage in the three or six months following RADAR continue throughout the year. The data for three and six months is relatively consistent for hospital admissions, although it is derived from different sampling approaches. There would be no reason to believe that the impact seen in the first six months after RADAR would suddenly stop at the six month mark. There may be a gradual tailing-off on the impact, but the conclusion of this report on the cost-effectiveness of RADAR is that there is a projected saving of £ 1,320,921 over a 12 month period.

Appendix

1.1. Table of descriptive statistics for patient outcomes pre- and post-RADAR.

	N	Minimum	Maximum	Mean	Std. Deviation
A&E Visits before RADAR	97	0	89	3.16	9.28
A&E Visits after RADAR	96	0	6	.55	1.15
GP Visits before RADAR	98	0	52	4.5	8.29
GP Visits after RADAR	95	0	26	3.01	5.80
Overnight stay in hospital before RADAR	98	0	89	2.26	9.31
Overnight stay in hospital after RADAR	96	0	3	.29	.65

1.2. Table of Wilcoxon's test results

	Z	Sig. (2-tailed)
Amount of times visited A&E	-5.79	.000
Amount of times visited GP		.03
Amount of time had overnight stay in hospital	-5.28	.000

1.3.Table of frequencies for patient outcomes pre- and post-RADAR

			Frequency	Percent	Valid Percent
Attended alcohol service before RADAR	Valid	0	5251	52.0	53.1
		1	4145	45.9	46.9
		Total	9596	98.0	100.0
	Missing	System	42	2.0	
	Total		98	100	
Attended alcohol service after RADAR	Valid	0	22	22.4	22.7
		1	75	76.5	77.3
		Total	97	99.0	100.0
	Missing	System	1	1.0	
	Total		98	100.0	
Attended self-help group before RADAR	Valid	0	49	50.0	50.5
		1	48	49.0	49.5
		Total	97	99.0	100.0
	Missing	System	1	1.0	
	Total		98	100.0	
Attended self-help group after RADAR	Valid	0	49	50.0	50.5
		1	48	49.0	49.5
		Total	97	99.0	100.0
	Missing	System	1	1.0	
	Total		98	100.0	

1.4 Table of frequencies for attending self-help groups

	Frequency	Percent
Never	31	31.6
Both before and after	30	30.6
Before and not after	18	18.4
After but not before	18	18.4

1.5. Table of frequencies for patient rating of their alcohol use post-RADAR

		Frequency	Percent	Valid Percent
Valid	1	51	51.6	52.6
	2	8	8.2	8.2
	3	7	7.2	7.2
	4	3	3.1	3.1
	5	2	2.1	2.1
	6	2	2.1	2.1
	7	6	6.2	6.2
	8	4	4.1	4.1
	9	4	4.1	4.1
	10	10	10.2	10.3
	Total	97	99.0	100.0
Missing	System	1	1.0	
	Total	98	100.0	

1.6. Table of frequencies for amount of alcohol patients drinking post-RADAR in comparison to pre-RADAR

		Frequency	Percent	Valid Percent
Valid	More	5	5.1	5.5
	Less	86	87.8	94.5
	Total	91	92.9	100.0
Missing	System	7	7.1	
Total		98	100.0	

1.7. Table of frequencies for patient gender

			Frequency	Percent
538 Patients	Valid	Male	363	67.5
		Female	175	32.5
	Total		538	100.0
Telephone Survey Participants	Valid	Male	66	67.3
		Female	32	32.7
		Total	98	100.0
Total 636 Patients	Valid	Male	429	67.5
		Female	207	32.5
	Total		636	100.0

1.8. Chi-square for patient gender

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.001[a]	1	.981
N of Valid Cases	636		

1.9. Table of frequencies for patient ethnicity

			Frequency	Percent
538 Patients	Valid	White	521	97.0
		Black Caribbean	3	.6
		Mixed race	3	.6
		Asian	4	.7
		Other	6	1.1
		Total	537	100.0
	Missing	System	1	
	Total		538	
Telephone Survey Participants	Valid	White	92	93.9
		Black Caribbean	2	2.0
		Mixed race	1	1.0
		Asian	1	1.0
		Other	2	2.0
		Total	98	100.0
Total 636 Patients	Valid	White	613	96.5
		Black Caribbean	5	.8
		Mixed race	4	.6
		Asian	5	.8
		Other	8	1.3
		Total	635	100.0
	Missing	System	1	
	Total		636	

2.0. Chi-square for patient ethnicity

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.318[a]	4	.506
N of Valid Cases	635		

2.1. Table of frequencies for patient relationship status

			Frequency	Percent
538 Patients	Valid	Married	64	12.1
		Divorced	53	10.0
		Single	315	59.5
		Cohabit	40	7.6
		Separated	47	8.9
		Widowed	10	1.9
		Total	529	100.0
	Missing	System	9	
	Total		538	
Telephone Survey Participants	Valid	Married	19	19.8
		Divorced	18	18.8
		Single	43	44.8
		Cohabit	6	6.3
		Separated	9	9.4
		Widowed	1	1.0
		Total	96	100.0
	Missing	System	2	
	Total		98	
Total 636 Patients	Valid	Married	83	13.3
		Divorced	71	11.4
		Single	358	57.3
		Cohabit	46	7.4
		Separated	56	9.0
		Widowed	11	1.8
		Total	625	100.0
	Missing	System	11	
	Total		636	

2.2. Chi-square of patient relationship status

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.706[a]	5	.026
N of Valid Cases	625		

2.3. Table of frequencies for employment status

			Frequency	Percent
538 Patients	Valid	Employed	99	18.9
		Unemployed	353	67.2
		Long term sick	38	7.2
		Home maker	8	1.5
		Retired	26	5.0
		Education	1	.2
		Total	525	100.0
	Missing	System	13	
	Total		538	
Telephone Survey Participants	Valid	Employed	15	15.8
		Unemployed	64	67.4
		Long term sick	7	7.4
		Home maker	4	4.2
		Retired	4	4.2
		Education	1	1.1
		Total	95	100.0
	Missing	System	3	
	Total		98	
Total 636 Patients	Valid	Employed	114	18.4
		Unemployed	417	67.3
		Long term sick	45	7.3
		Home maker	12	1.9
		Retired	30	4.8
		Education	2	.3
		Total	620	100.0
	Missing	System	16	
	Total		636	

2.4. Chi-square of patient employment status

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.359[a]	5	.374
N of Valid Cases	620		

2.5. Table of frequencies for participant accommodation status

			Frequency	Percent
538 Patients	Valid	Non-settled	83	15.7
		Not disclosed	12	2.3
		Settled	433	82.0
		Total	528	100.0
	Missing	System	10	
	Total		538	
Telephone Survey Participants	Valid	Non-settled	7	7.5
		Not disclosed	1	1.1
		Settled	85	91.4
		Total	93	100.0
	Missing	System	5	
	Total		98	
Total 636 Patients	Valid	Non-settled	90	14.5
		Not disclosed	13	2.1
		Settled	518	83.4
		Total	621	100.0
	Missing	System	15	
	Total		636	

2.6. Chi-square of patient accommodation status

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.040[a]	2	.080
N of Valid Cases	621		

2.7. Table of frequencies for frequent flyers

			Frequency	Percent
538 Patients	Valid	No	196	55.1
		Yes	160	44.9
		Total	356	100.0
	Missing	System	182	
	Total		538	
Telephone survey participants	Valid	No	52	82.5
		Yes	11	17.5
		Total	63	100.0
	Missing	System	35	
	Total		98	
Total 636 Patients	Valid	No	248	59.2
		Yes	171	40.8
		Total	419	100.0
	Missing	System	217	
	Total		636	100.0

2.8. Chi-square for number of frequent flyers

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.738[a]	1	.000
N of Valid Cases	419		

2.9. Table of frequencies for referring hospital

			Frequency	Percent
538 Patients	Valid	Salford Royal	99	18.4
		Wigan & Leigh Infirmary	74	13.8
		MRI	68	12.6
		NMGH	27	5.0
		ROH	32	5.9
		RBH	47	8.7
		Fairfield	23	4.3
		Rochdale	22	4.1

		Stepping Hill	29	5.4
		Wythenshawe	38	7.1
		Tameside	46	8.6
		Trafford	33	6.1
		Total	538	100.0
Telephone Survey Participants	Valid	Salford Royal	27	27.6
		Wigan & Leigh Infirmary	6	6.1
		MRI	13	13.3
		NMGH	4	4.1
		ROH	6	6.1
		RBH	12	12.2
		Fairfield	2	2.0
		Rochdale	3	3.1
		Stepping Hill	5	5.1
		Wythenshawe	7	7.1
		Tameside	6	6.1
		Trafford	7	7.1
		Total	98	100.0
Total 636 Patients	Valid	Salford Royal	126	19.8
		Wigan & Leigh Infirmary	80	12.6
		MRI	81	12.7
		NMGH	31	4.9
		ROH	38	6.0
		RBH	59	9.3
		Fairfield	25	3.9
		Rochdale	25	3.9
		Stepping Hill	34	5.3
		Wythenshawe	45	7.1
		Tameside	52	8.2
		Trafford	40	6.3
		Total	636	100.0

3.1. Chi-square of referring hospital

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.642[a]	11	.474
N of Valid Cases	636		

3.2. Table of frequencies for referring ward

			Frequency	Percent
538 Patients	Valid	A&E	185	34.5
		AAA/CDU	87	16.2
		EAU/MAU	154	28.7
		General ward	111	20.7
		Total	537	100.0
	Missing	System	1	
	Total		538	
Telephone Survey Participants	Valid	A&E	30	30.6
		AAA/CDU	20	20.4
		EAU/MAU	33	33.7
		General ward	15	15.3
		Total	98	100.0
Total 636 Patients	Valid	A&E	215	33.9
		AAA/CDU	107	16.9
		EAU/CDU	187	29.4
		General ward	126	19.8
		Total	635	100.0
	Missing	System	1	
	Total		636	

3.3. Chi-square for referring ward

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.135[a]	3	.371
N of Valid Cases	635		

3.4. Table of frequencies for reason for presentation at hospital

Tel			Frequency	Percent
538 Patients	Valid	Fall/Collapse/Head Injury	36	7.3
		Fit/Seizure/Withdrawal/intoxicated/alcoholdependent	268	54.7
		Suicide/Self Harm/OD	142	29.0
		Physical problems	44	9.0
		Total	490	100.0
	Missing	System	48	
	Total		538	
Telephone Survey Participants	Valid	Fall/Collapse/Head Injury	4	4.4
		Fit/Seizure/Withdrawal/intoxicated/alcoholdependent	52	57.8
		Suicide/Self Harm/OD	23	25.6
		Physical problems	11	12.2
		Total	90	100.0
	Missing	System	8	
	Total		98	
Total 636 patients	Valid	Fall/Collapse/Head Injury	40	6.9
		Fit/Seizure/Withdrawal/intoxicated/alcoholdependent	320	55.2
		Suicide/Self Harm/OD	165	28.4
		Physical problems	55	9.5
		Total	580	100.0
	Missing	System	56	
	Total		636	

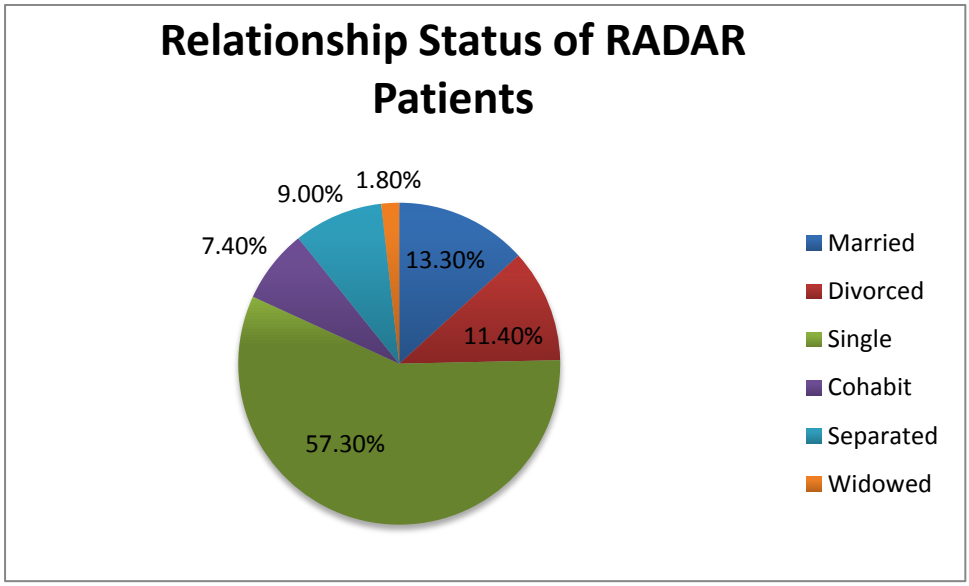
3.5. Chi-square of reason for presentation at hospital

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.216[a]	3	.529
N of Valid Cases	580		

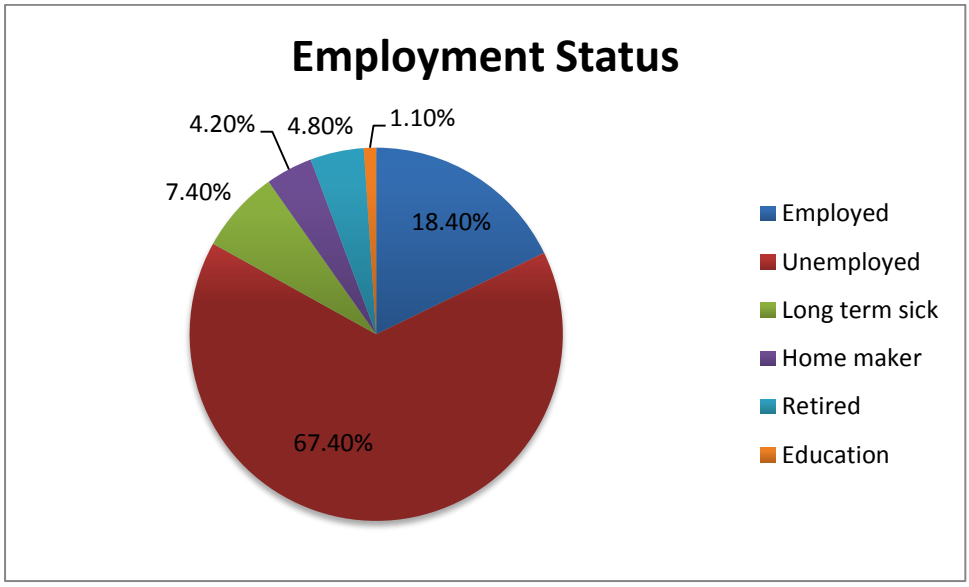
3.6. Table of means

		Minimum	Maximum	Mean	Std. Deviation
538 Patients	Age in Years	18	76	43.21	10.775
	No.Presentations last 6 months	0	52	3.50	5.723
	AUDIT total score at admission	0	40	31.00	10.146
	CISS total score at admission	0	20	8.86	3.282
	No. units per week at admission	0	903	228.85	127.679
Telephone survey participants	Age in Years	21	71	47.00	9.248
	No.Presentations last 6 months	0	31	2.06	3.955
	AUDIT total score at admission	0	40	31.78	9.028
	CISS total score at admission	3	15	8.46	2.843
	No. units per week at admission	0	749	223.94	130.652
Total 636 Patients	Age in Years	18	76	44	10.64
	No.Presentations last 6 months	0	52	3	5.51
	AUDIT total score at admission	0	40	31.12	9.98
	CISS total score at admission	0	20	8.79	3.21
	No. units per week at admission	0	903	228.11	128.04

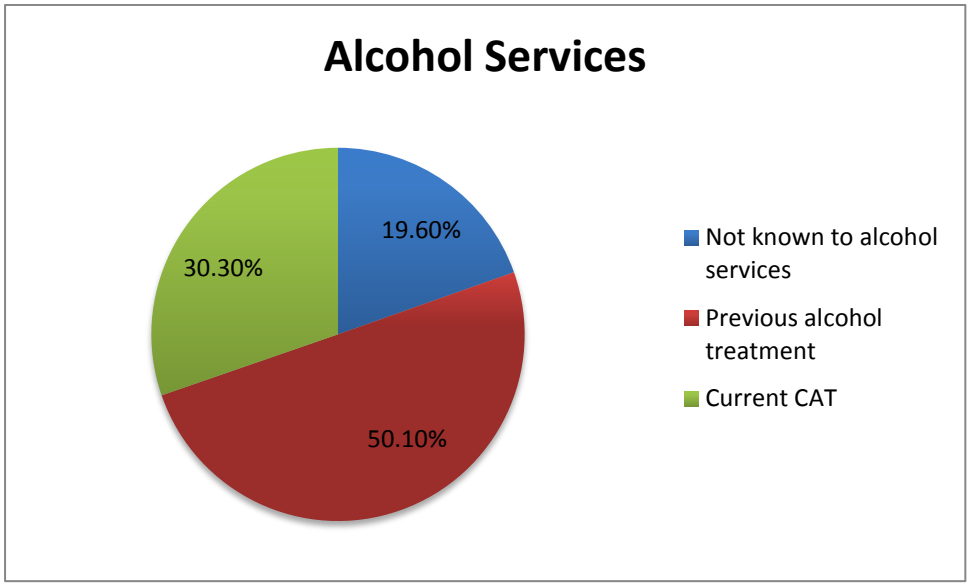
3.7.Relationship status of patients on arrival at RADAR



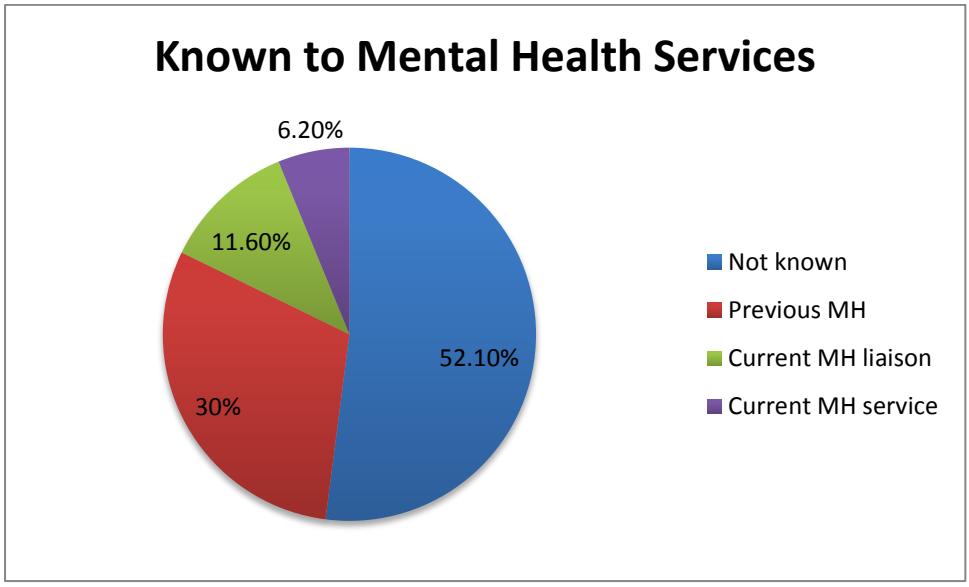
3.8.Employment status of patients on arrival at RADAR



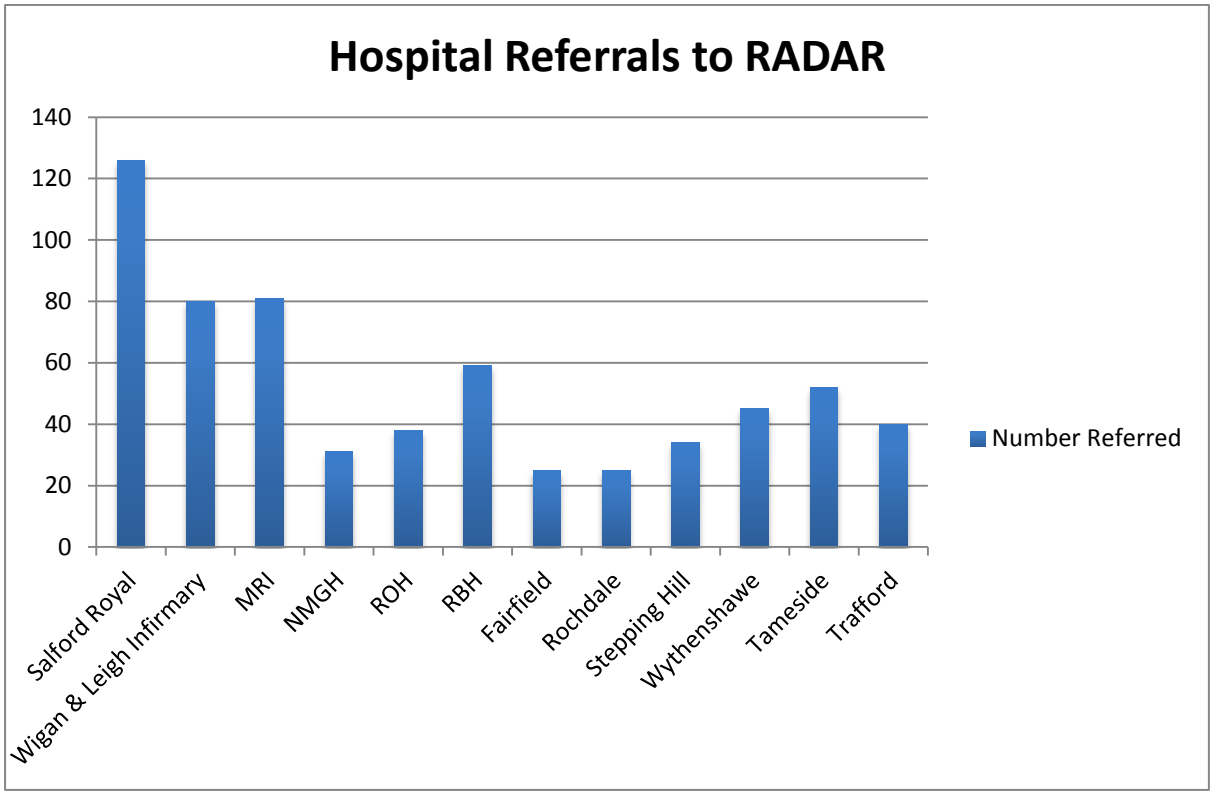
3.9.Patients status within alcohol services on arrival at RADAR



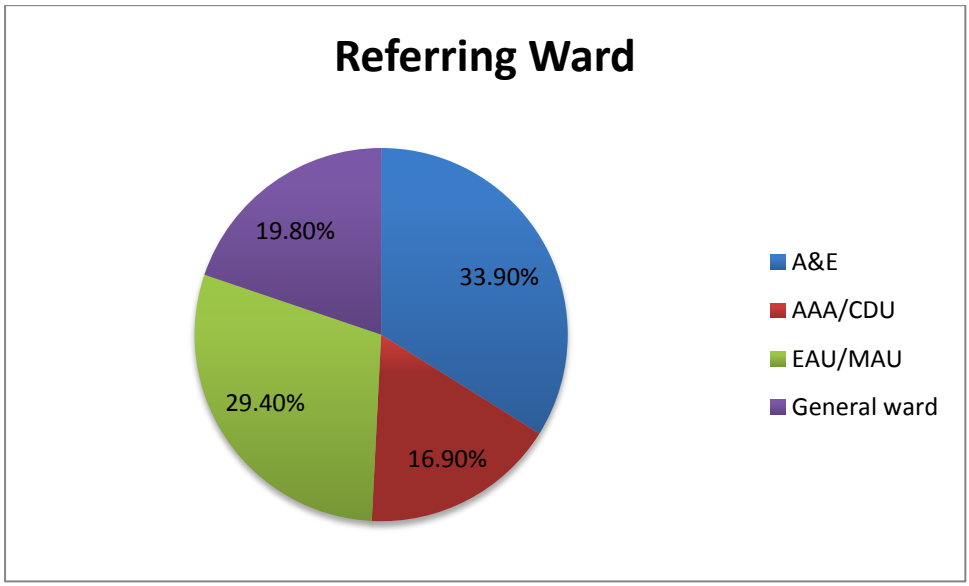
4.0.Patient status within mental health services on arrival at RADAR



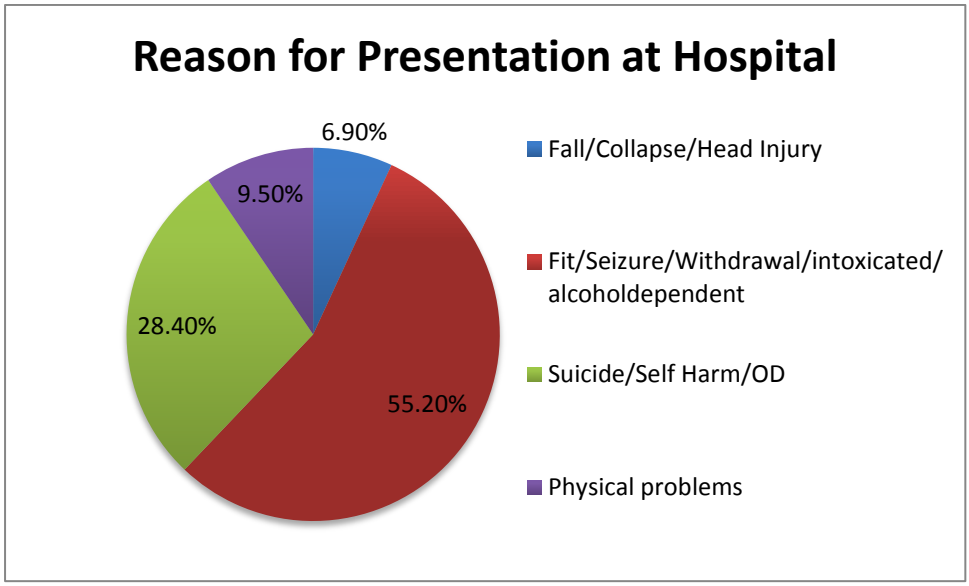
4.1.Hospital referrals to RADAR within the first two years that RADAR was open



4.2.Ward referrals to RADAR within the first two years that RADAR was open



4.3.Reason for presentation to hospital



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