



Public Health  
England

# **NDTMS provider survey February 2014**

## **Regional report – Eastern**

## About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England  
133-155 Waterloo Road  
Wellington House  
London SE1 8UG  
Tel: 020 7654 8000  
<http://www.gov.uk/phe>  
Twitter: @PHE\_uk

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# Introduction

The National Drug Treatment Monitoring System (NDTMS) captures data on the numbers of people presenting to English services with problematic drug and alcohol misuse. There are 8 regional NDTMS teams based across the country supporting the processes required for ensuring that the ongoing primary data collection is maintained and that monthly deadlines and quality targets are met.

In January 2014 all drug and alcohol treatment providers in England, reporting to NDTMS were requested to complete a national survey relating to topic areas as agreed with the central and regional NDTMS teams. The survey included questions around software providers, information governance, business continuity, the frequency of reviews and mutual aid referrals. It also recorded the respondent's name, contact details, NDTMS region, parent organisation and agency codes.

## Aims

The aim of the survey was to provide information to regional and central NDTMS teams, PHE Alcohol & Drug team colleagues and individual partnerships with regards to the ongoing timely delivery of high quality data around drug and alcohol treatment in England.

## Objectives

To gather information on a national, regional, DAT and organisational level in relation to:

- **Systems:** To verify software systems used, how they are accessed and to obtain information in relation to planned migrations of data from or to NDTMS or Case Management systems.
- **Information Governance:** To verify awareness and use of the NDTMS Consent and Confidentiality Tool Kit V6.3 and to assess password security.
- **Business Continuity:** To verify the presence of a Business Continuity plan for each provider, including a timetable for backups and information in relation to the resilience of data entry.
- **Frequency of Reviews:** To verify the frequency of Sub Intervention Reviews and Outcomes Records (TOP, AOR and YPOR).
- **Mutual Aid:** To verify that agencies are referring clients to mutual aid organisations (for example Alcoholic Anonymous and Narcotics Anonymous) and that these referrals are being recorded on NDTMS systems.

This report will be made available to NDTMS teams, PHE Alcohol and Drug leads and alcohol and drug commissioners.

Unless otherwise stated, this report includes all English alcohol and drug treatment providers in the community, for young people and adults reporting to NDTMS.

Please note, percentages may not always add up to 100% due to rounding. Percentages are based on the denominator of the number of providers completing the survey.

## Overall survey completion rates

**Table 1. National survey completion rates**

Region	Number of providers	Number of providers with completed surveys	Completion rate %
Northern & Yorkshire – Yorkshire & Humber	187	124	66.3
Northern & Yorkshire – North East	98	68	69.4
North West	149	118	79.2
South East	147	125	85.0
South West	79	66	83.5
London	247	158	64
West Midlands	103	80	77.7
East Midlands	67	22	32.8
Eastern	94	57	60.6
<b>Total</b>	<b>1172</b>	<b>812</b>	<b>69.3</b>

The national rate of completion of this survey was 69.3%. Completion rates varied across NDTMS regions. The highest completion rate was in the South East where 85% of providers completed the survey.

Where returns have been made, there can be some reassurance to the commissioning local authority that there is less chance of system changes being made or planned without the knowledge and involvement of regional NDTMS teams and any resulting discontinuity in national statistics and monitoring information.

This survey has followed on from practice prior to NDTMS transition to PHE of varying degrees of information gathering at regional level and has been the first year that a national survey has been completed. It is hoped that there will be an improvement in completion of this survey next year and teams are continuing to pursue completion for this year outside of this analysis.

**Table 2. Eastern survey completion rates by Partnership**

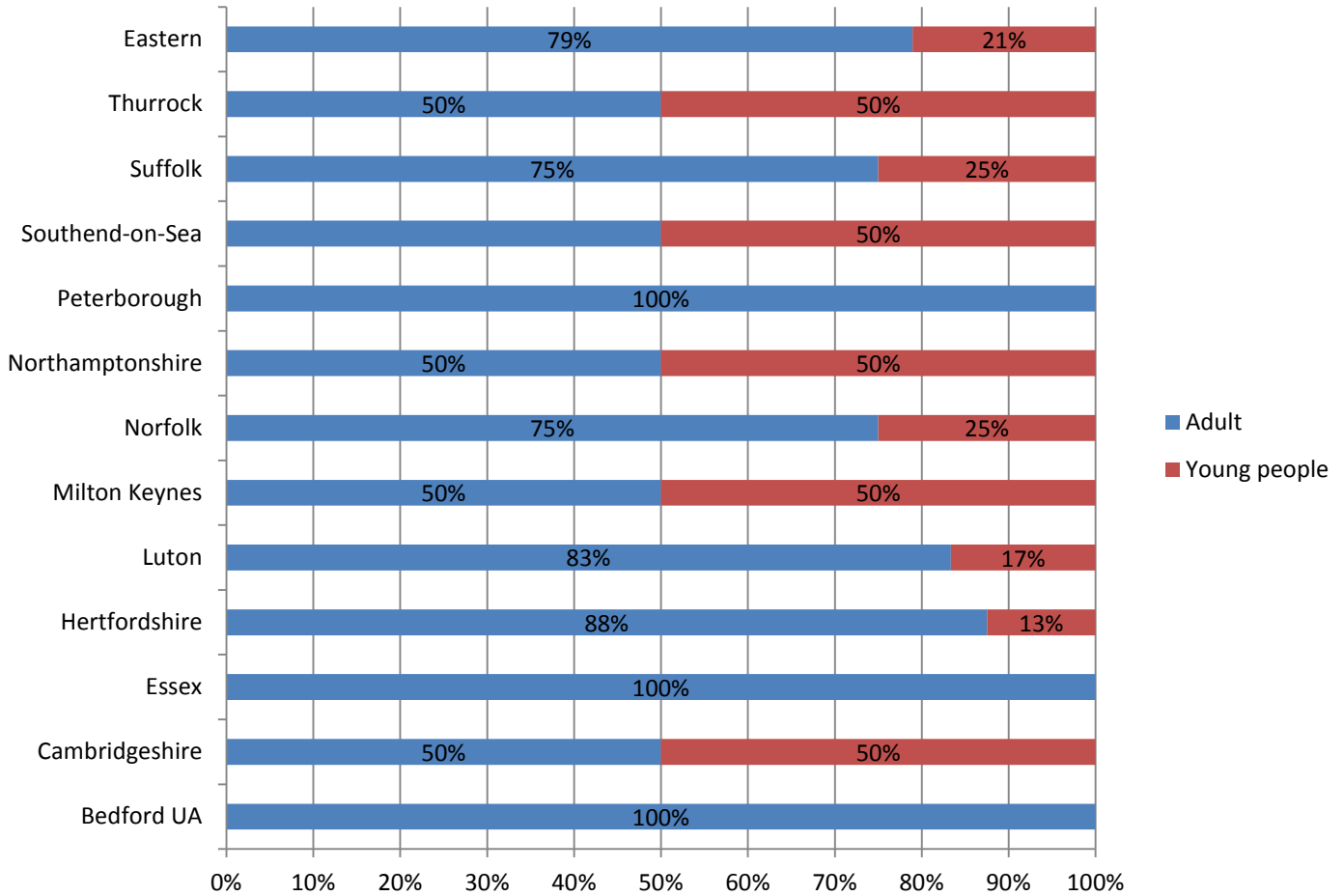
<b>Partnership code</b>	<b>Partnership name</b>	<b>Number of providers</b>	<b>Number of providers with completed surveys</b>	<b>Completion rate %</b>
G01B	Bedfordshire	5	1	20.0
G03B	Cambridgeshire	13	4	61.5
G05B	Essex	24	13	54.2
G08B	Hertfordshire	10	8	80.0
G02B	Luton	13	6	46.2
J08B	Milton Keynes	2	2	100.0
G09B	Norfolk	9	8	89.0
E09B	Northamptonshire	2	2	100.0
G04B	Peterborough	6	1	16.7
G06B	Southend-on-Sea	3	2	66.6
G10B	Suffolk	9	8	88.9
G07B	Thurrock	3	2	66.7
<b>Total</b>		<b>94</b>	<b>57</b>	<b>60.6</b>

A full list of Eastern providers who completed the survey can be found in Appendix 1.

Overall, 60.6.% of Eastern providers responded to the survey with services from 2 out of 12 local authority areas fully responding.

# Provider profiles

## What client group does your provider treat?

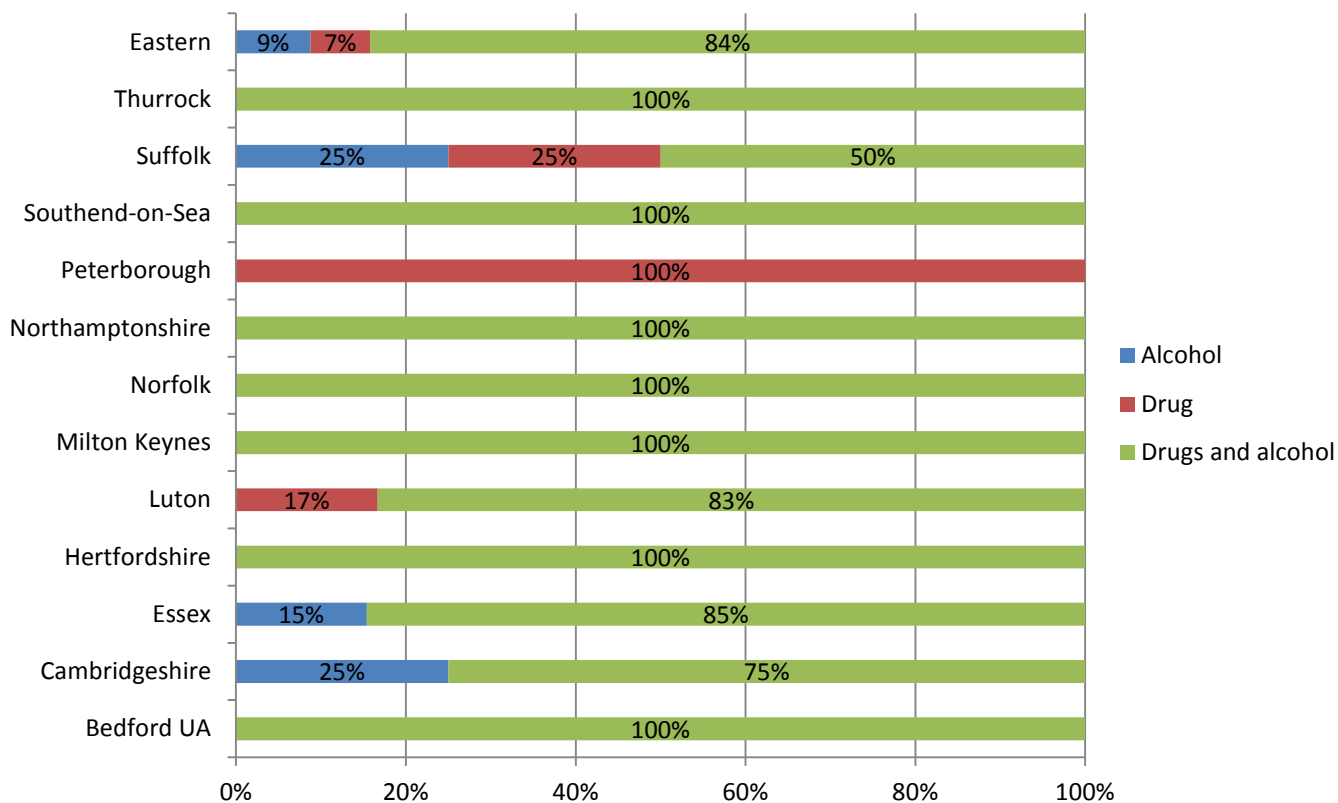


**Figure 1. Client group, for the Eastern region and by Partnership**

Regionally of the 57 providers who completed the survey, 79% report that they treat adult clients and 21% report that they treat young people. This distribution is generally consistent across other NDTMS regions and nationally there is an 81:19 ratio.



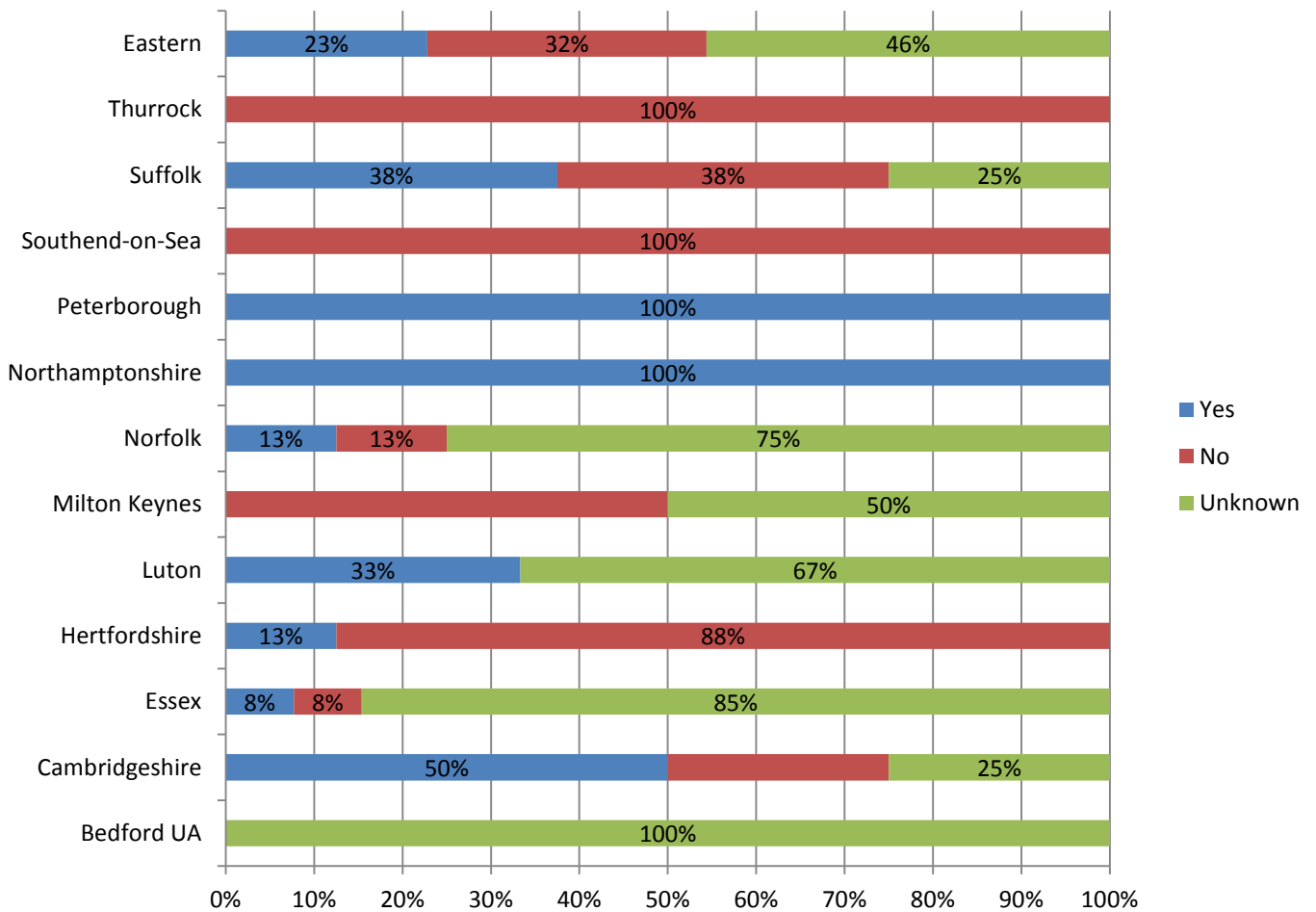
### What treatment service/s do you provide?



**Figure 2. Treatment service offered, for the Eastern region and by Partnership**

Figure 2 shows that of the providers that completed the survey, 9% offer alcohol only treatment, 7% offer drug only treatment and 84% offer both drug and alcohol treatment. This latter figure is the third highest when compared with other NDTMS regions.

## Do you have a Care Quality Commission (CQC) registration number?



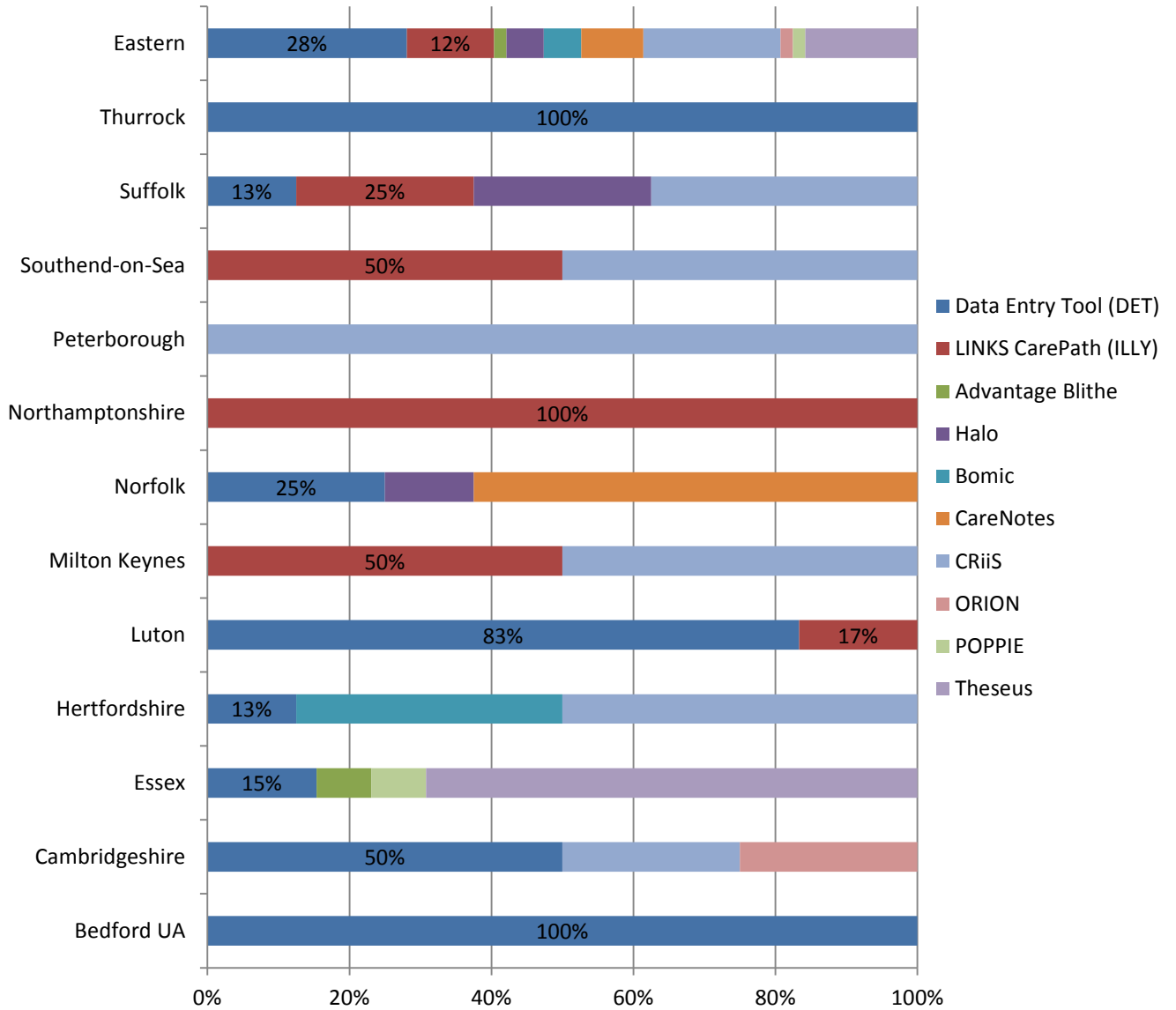
**Figure 3. CQC membership, for the Eastern region and by Partnership**

Twenty three per cent of survey respondents stated that they have a CQC registration number. Thirty two percent stated that they did not have a number and a further 46% did not know. Due to the number of providers who reported that they did not know, caution should be exercised when interpreting these results. We will endeavour to improve on this information in next years’ survey.

It should be noted that all residential drug and alcohol treatment providers should be registered and all community-based providers with nurses, doctors, social workers or psychologists employed as such are also required to be CQC registered.

# NDTMS systems

What software system does your treatment service use to collect NDTMS data?

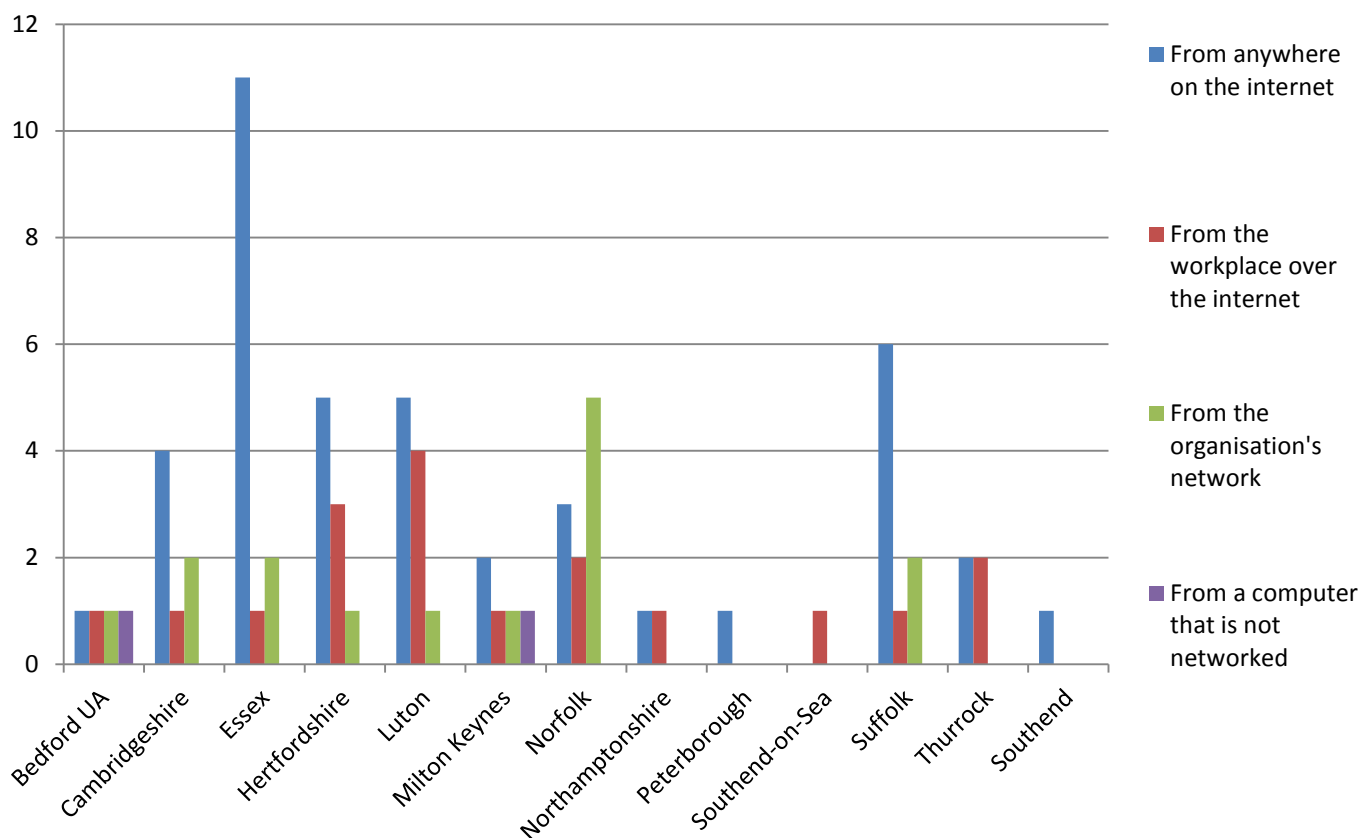


**Figure 4. Software provider, for the Eastern region and by Partnership**

Surprisingly, there are at least 9 systems apart from the NDTMS Data Entry Tool (DET) reported as in use in the Eastern region to generate a data extract for NDTMS purposes. There was wide variation in the use of these software systems regionally. The most popular software system is the NDTMS DET with 28%. The next most popular is the NDTMS CRiiS with 19%, closely followed by Theseus with 16%.

Some local areas such as Northamptonshire report across their treatment services with one system only. Others have multiple systems in use to provide NDTMS extract data, for example Essex with four.

## From where can staff access the system that you use to submit your NDTMS data?



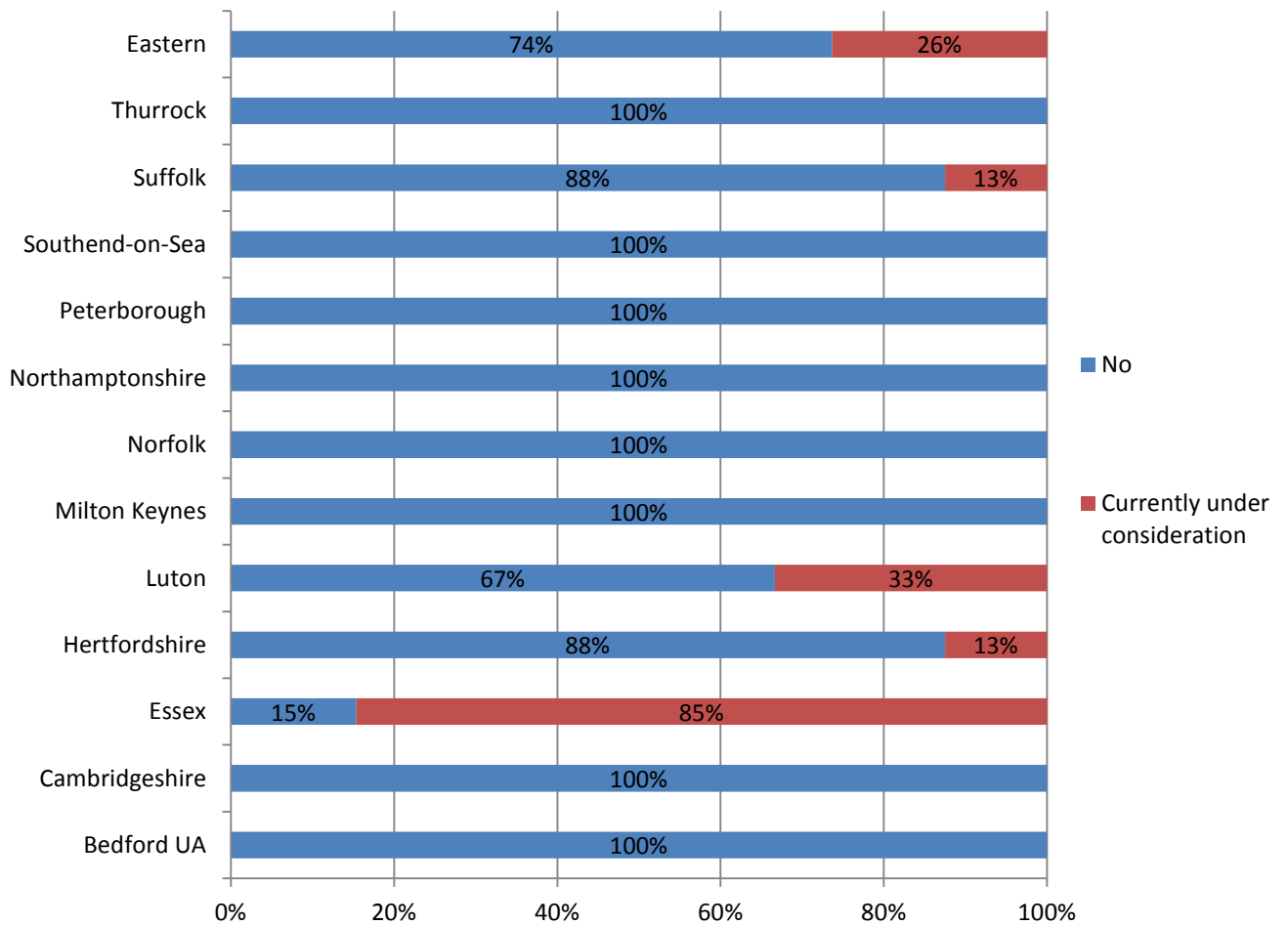
**Figure 5. System access methods by Partnership** (please note, respondents could select as many options as applicable for this question, therefore the categories are not mutually exclusive). Please note, where necessary answers have been corrected for DET Users who are able to access DET from anywhere over the internet.

Regionally, the most common method to access the system that is used to submit NDTMS data was from anywhere over the internet (n=42).

An NDTMS extract system that is able to provide access from anywhere over the internet may be less vulnerable to disruption following certain types of critical incidents requiring the short term relocation of administrators/key workers.

Responses from DET users indicated that there are misconceptions about the capabilities of DET, which may in fact be accessed from anywhere over the internet. It would be beneficial for managers of DET system services to understand this and factor it into their own business continuity planning.

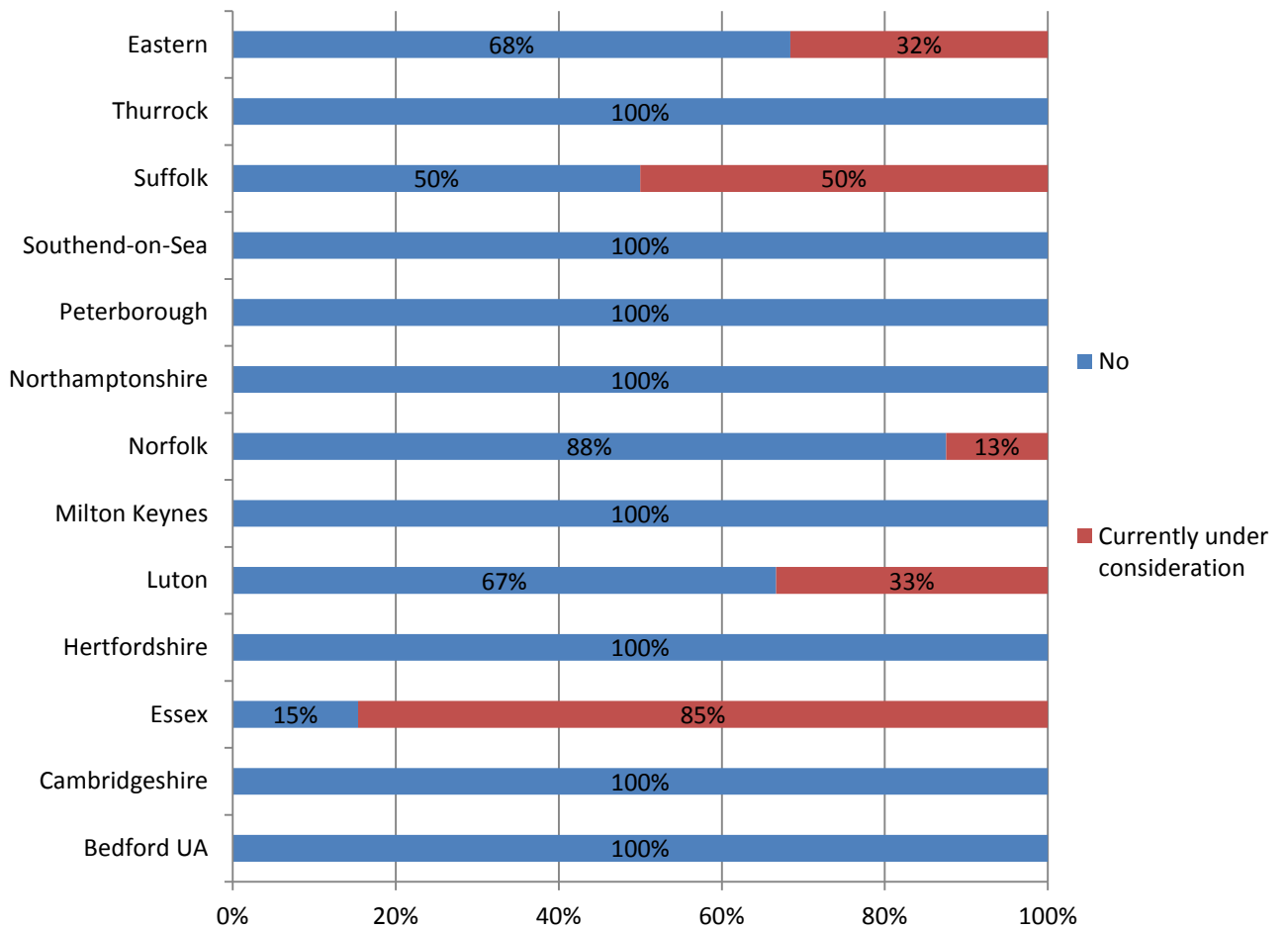
### Are you considering changing your NDTMS systems?



**Figure 6. Software migration intentions, for the Eastern region and by Partnership**

Figure 6 shows that regionally 26% of providers reported currently considering changing their software system. This compares to a lower figure of 11% nationally, and gives the NDTMS team an indication of where software use is less stable in the East. The main exceptions are Essex and Luton where at least a third of their services reported considering changes.

## Are you considering changing your Case Management System?



**Figure 7. Intentions to change Case Management System, for the Eastern region and by Partnership**

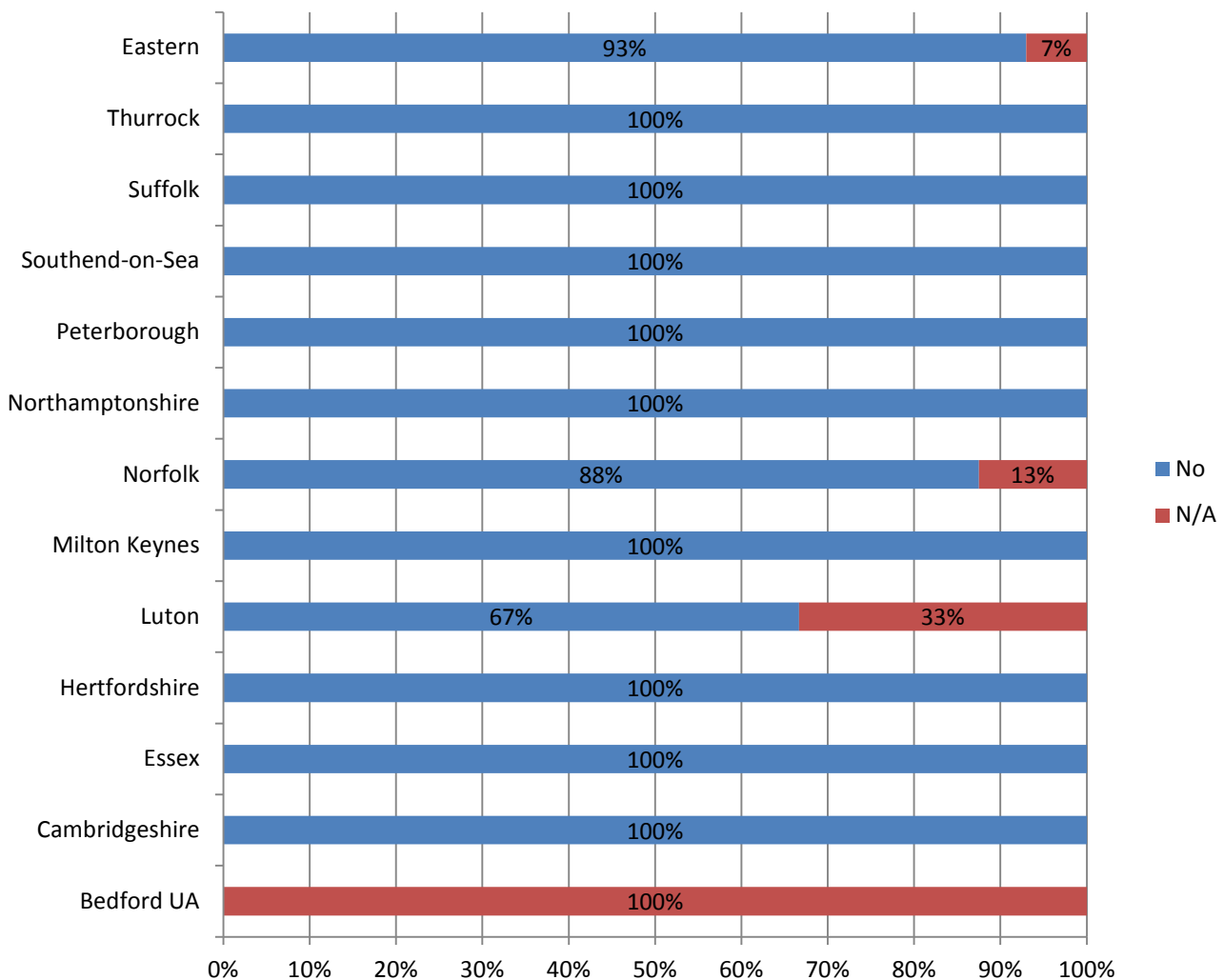
Figure 7 shows that 32% of providers regionally are currently considering changing their case management system (CMS) which is higher than the national percentage of 11%. This gives the Eastern NDTMS team an indication that CMS system choice is currently relatively unstable. In Essex, Suffolk and Luton, at least a third of their services are considering changing their CMS.

# Information governance

Respondents were asked whether staff at their organisation allowed other people to use their login details for the following systems (n/a indicates that the provider does not have access to that system).

It is strongly recommended that staff are not permitted to share passwords to any of these systems in the interests of security.

## Drug and Alcohol Monitoring System (DAMS)



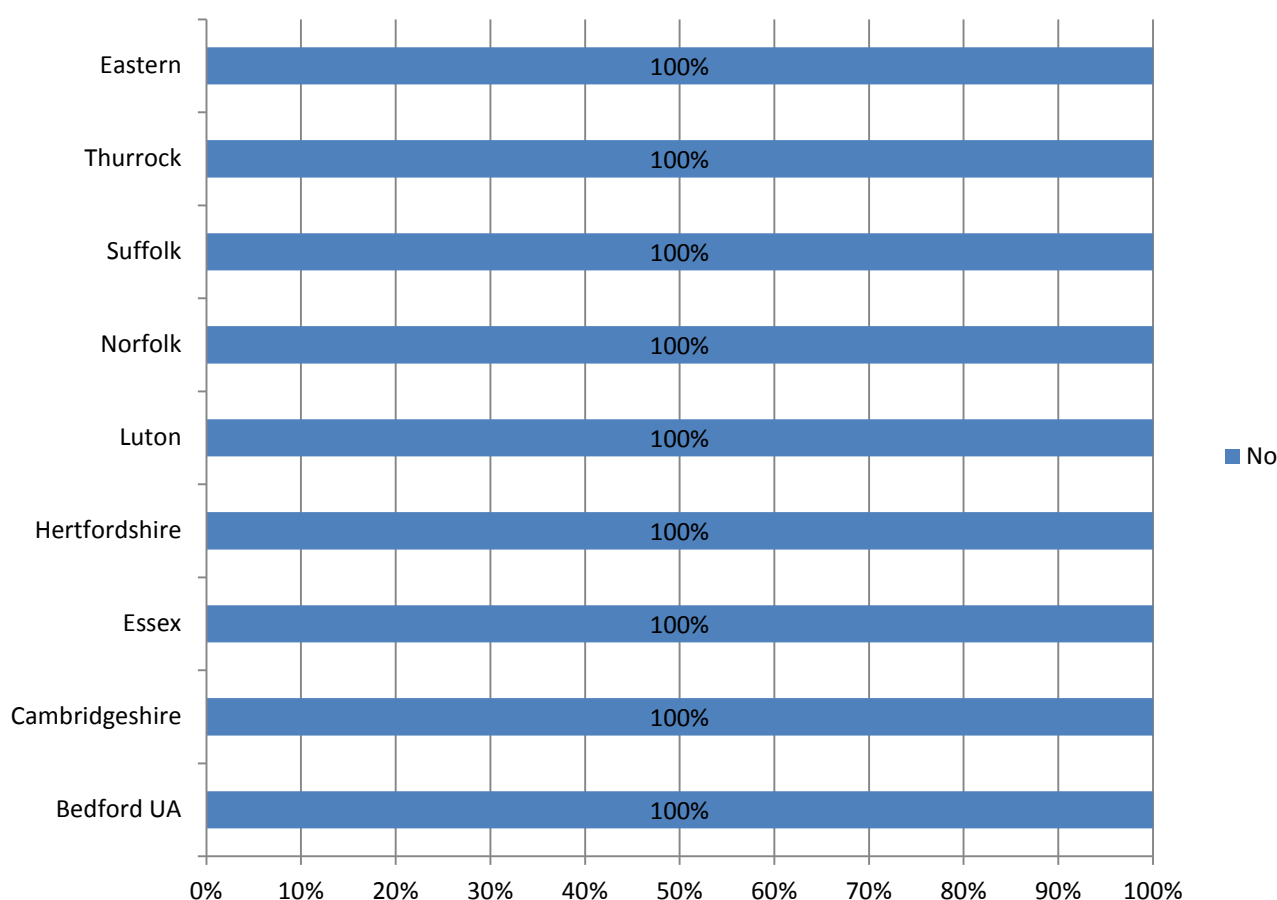
**Figure 8. DAMS password sharing among staff, for the Eastern region and by Partnership**

Regionally, no respondents stated that DAMS passwords were shared amongst staff at their organisation. Whilst this figure is low nationally, this practice is not appropriate and should cease as it poses an information governance risk. Those respondents who have stated that

they do share passwords will be contacted by the NDTMS team to provide support and guidance if required including the creation of new DAMs accounts where needed.

It was also noted that some 7% of services stated that they do not have access to DAMs. As this is the sole way of submitting data to the NDTMS it seems likely that these respondents are mistaken. Again, this may highlight a training need and those respondents who stated “N/A” to this question will be contacted to see if the NDTMS team is able to provide further training on DAMs.

## Data Entry Tool (DET)



**Figure 9. DET password sharing among staff, for the Eastern region and by Partnership** (please note, for those who stated they were on a system other than DET their responses have been corrected to N/A where necessary) (n = 16)

For the vast majority of respondents (68%), this question was not applicable as they were on a system other than the DET. Figure 9 therefore only shows responses from 8 local authority areas with services using DET (n = 16).

Of respondents who are on DET, 100% stated that DET password sharing does not occur within their organisation. Whilst it is positive that this figure is so high, it is important that that



staff continue to not share their DET password with other staff members as this could become an information governance issue.

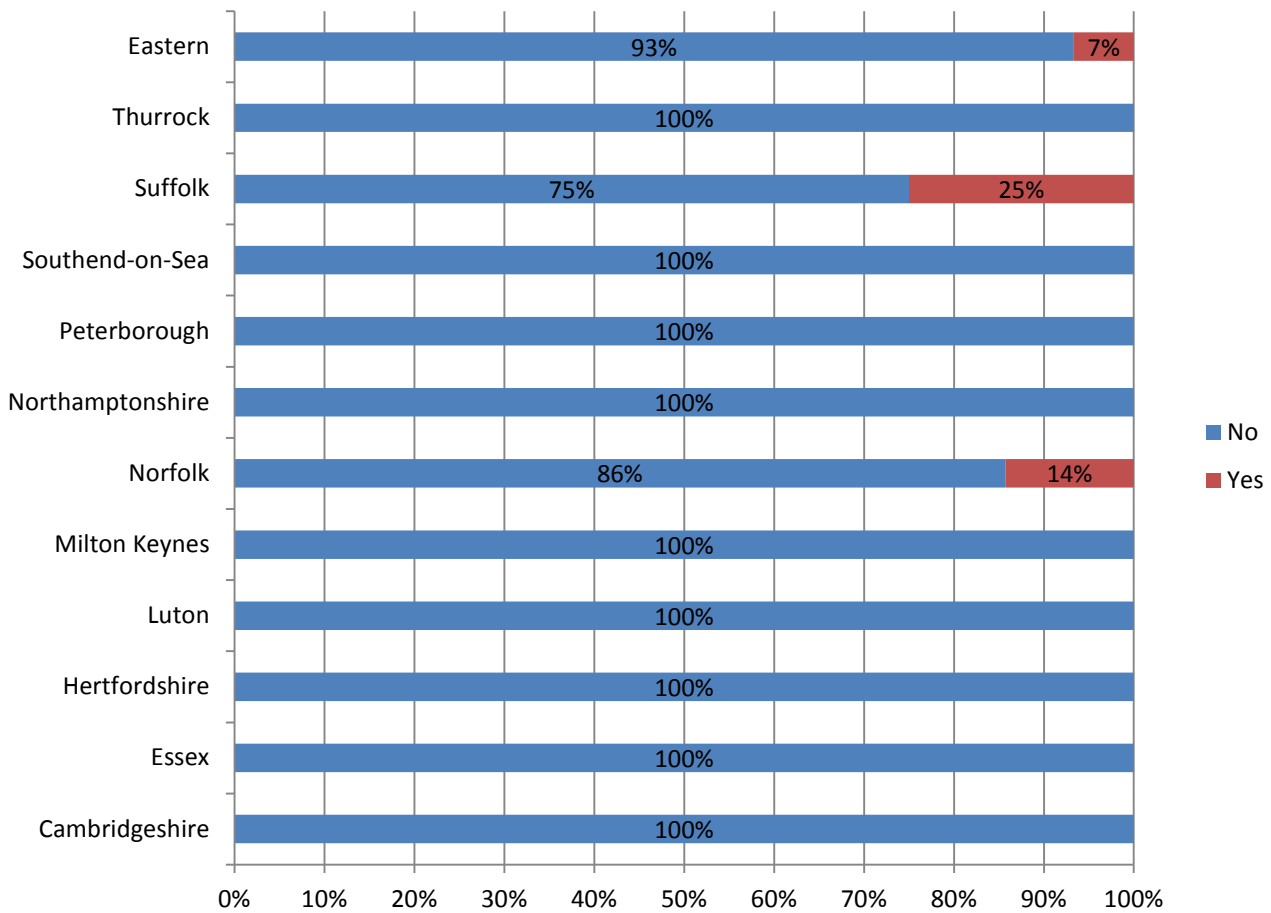
## Prison DET

Unsurprisingly, the majority of respondents (78%) stated that they did not have access to Prison DET. One hundred percent of respondents who did have access to prison DET stated that passwords were not shared among staff.

## CJIT Data Entry Tool (DIRDET)

Similarly, it is not surprising that the majority of respondents (84%) reported that this question was not applicable to them as they did not have access to the CJIT DET system as they were not CJIT providers. Of those who did have access to CJIT DET, 100% reported that staff did not share passwords.

### PHE Secure File Transfer System (SFT) (aka DropBox)



**Figure 10. SFT password sharing among staff, for the Eastern region and by Partnership (n = 45)**

Twenty one percent of respondents stated that this question was not applicable to them as they did not have access to the SFT.

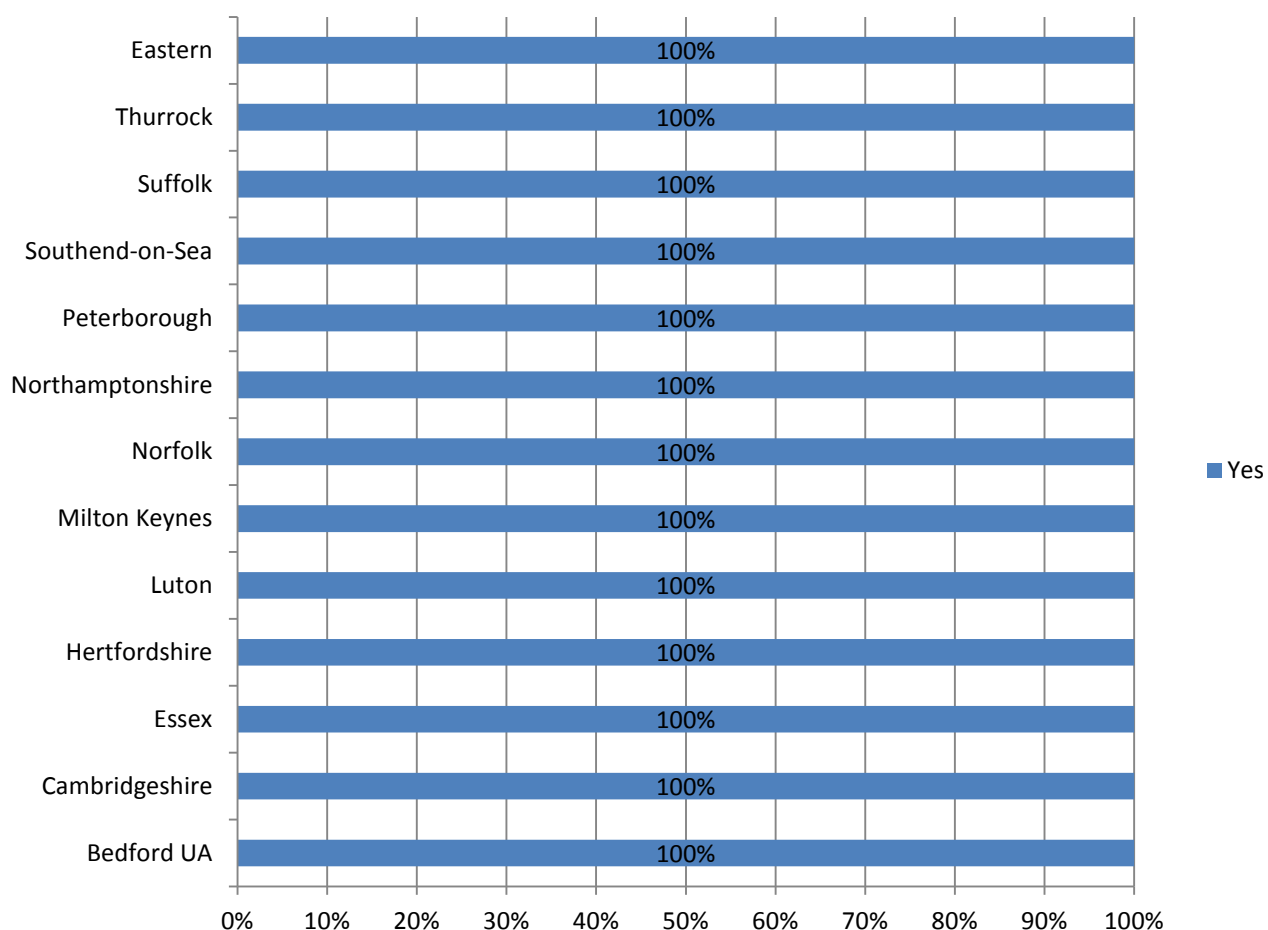
Of those who did have access to the SFT, 93% stated that they did not share their password with other staff members. However, 7% stated that they did. As above, those services where password sharing has been reported will be contacted by the NDTMS team to offer support and guidance.

### Needle Exchange Monitoring System (NEXMS)

The majority of respondents (90%) reported that they did not have access to NEXMS. One hundred percent of respondents who did have access to NEXMS stated that passwords were not shared among staff.

## Information governance - consent

Does your organisation’s consent policy include the latest version of the NDTMS Consent and Confidentiality Tool Kit version 6.3?



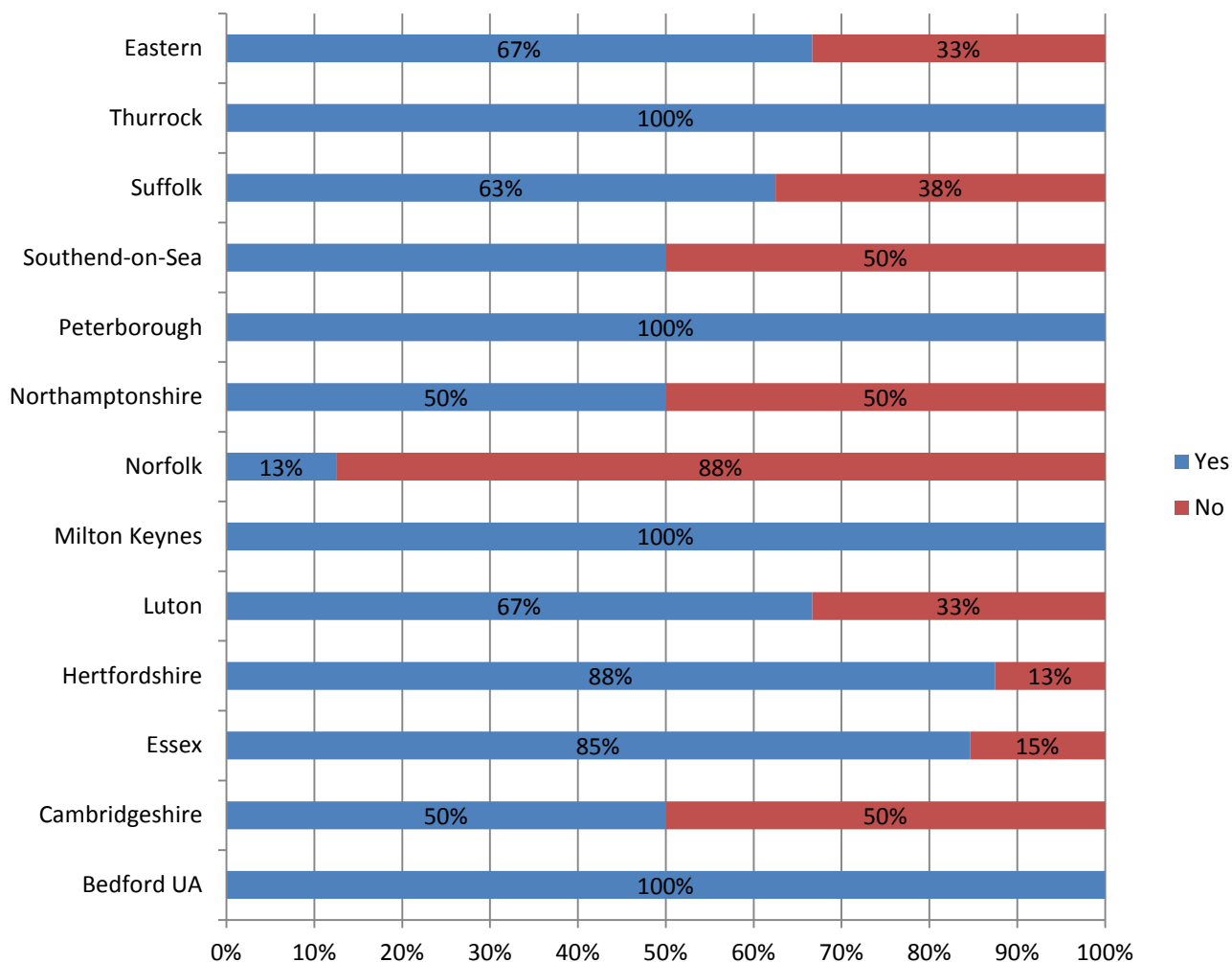
**Figure 11. Inclusion of NDTMS Consent and Confidentiality Toolkit V6.3 within organisation’s consent policy**

As can be seen from Figure 11, all services reported including the NDTMS Consent and Confidentiality Toolkit V6.3 within their organisation’s consent policy.

Unlike most health datasets, NDTMS is a “consented-to” dataset and it is extremely important that clients’ data on NDTMS is appropriately used according to the consent provided by individuals. The use of the most recent wording for consent is an intrinsic element of the agreement between the NDTMS programme and the Confidentiality Advisory Group (CAG) in granting Section 251 permission for the programme’s continued use of the data following transition into PHE.

## Business continuity

Does your organisation have an effective Business Continuity plan covering how your agency will continue to provide NDTMS data if your NDTMS system should fail?

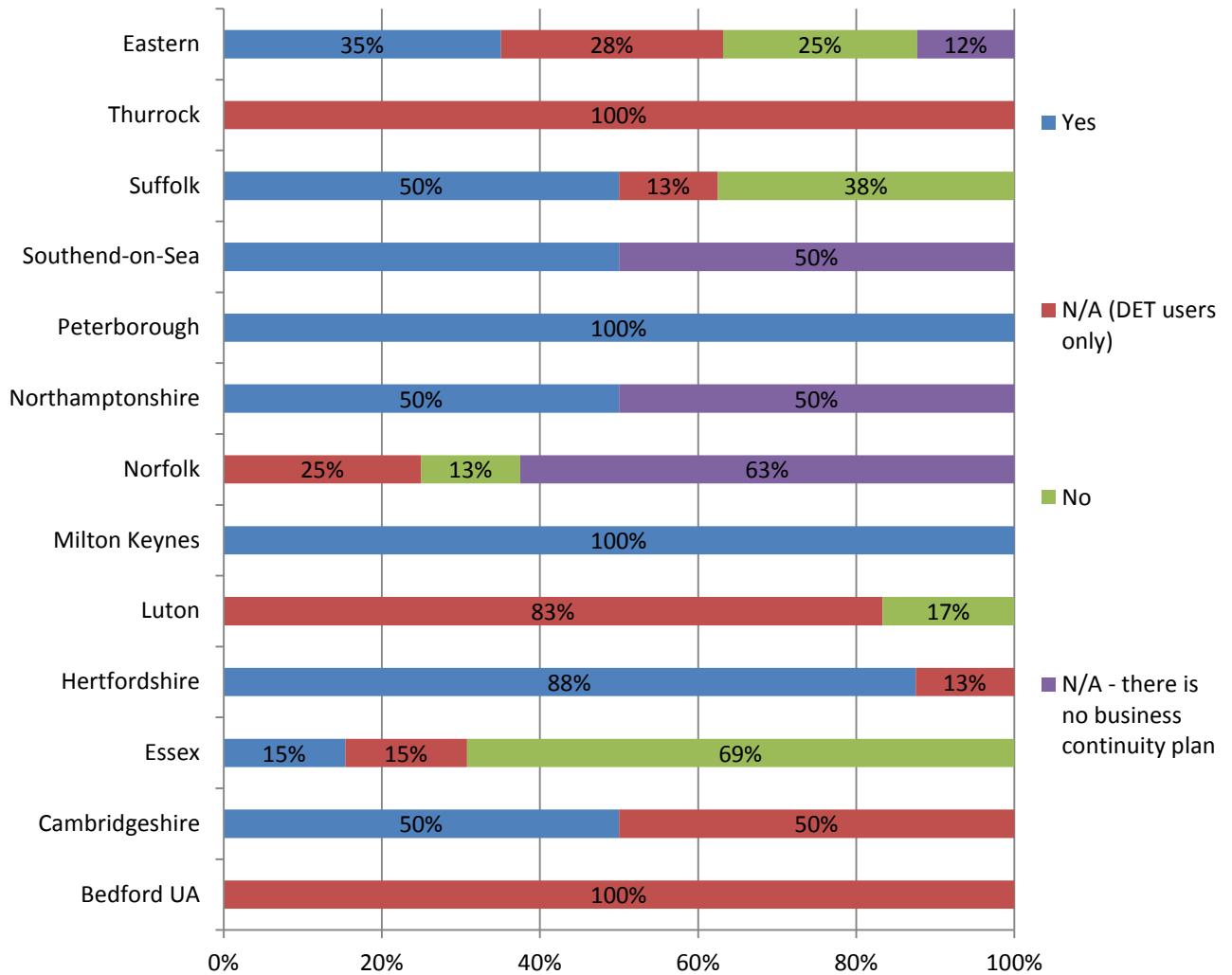


**Figure 12. Presence of a Business Continuity plan covering how agencies will submit data to the NDTMS if their NDTMS system should fail**

Regionally, 33% of services have a potential risk of non submission due to Business Continuity plans either not being in place or not being known to the member of staff who completed the survey.

Local authority areas where there is no Business Continuity plan should seek reassurance with regard to the continued capability of these services to provide NDTMS data on behalf of their treatment systems in a timely fashion regardless of the impact of staff absences, power shortage, structural damage to premises, etc. The NDTMS regional team can assist with such planning if required.

Does your Business Continuity plan incorporate a timetable for taking backups of your NDTMS data?

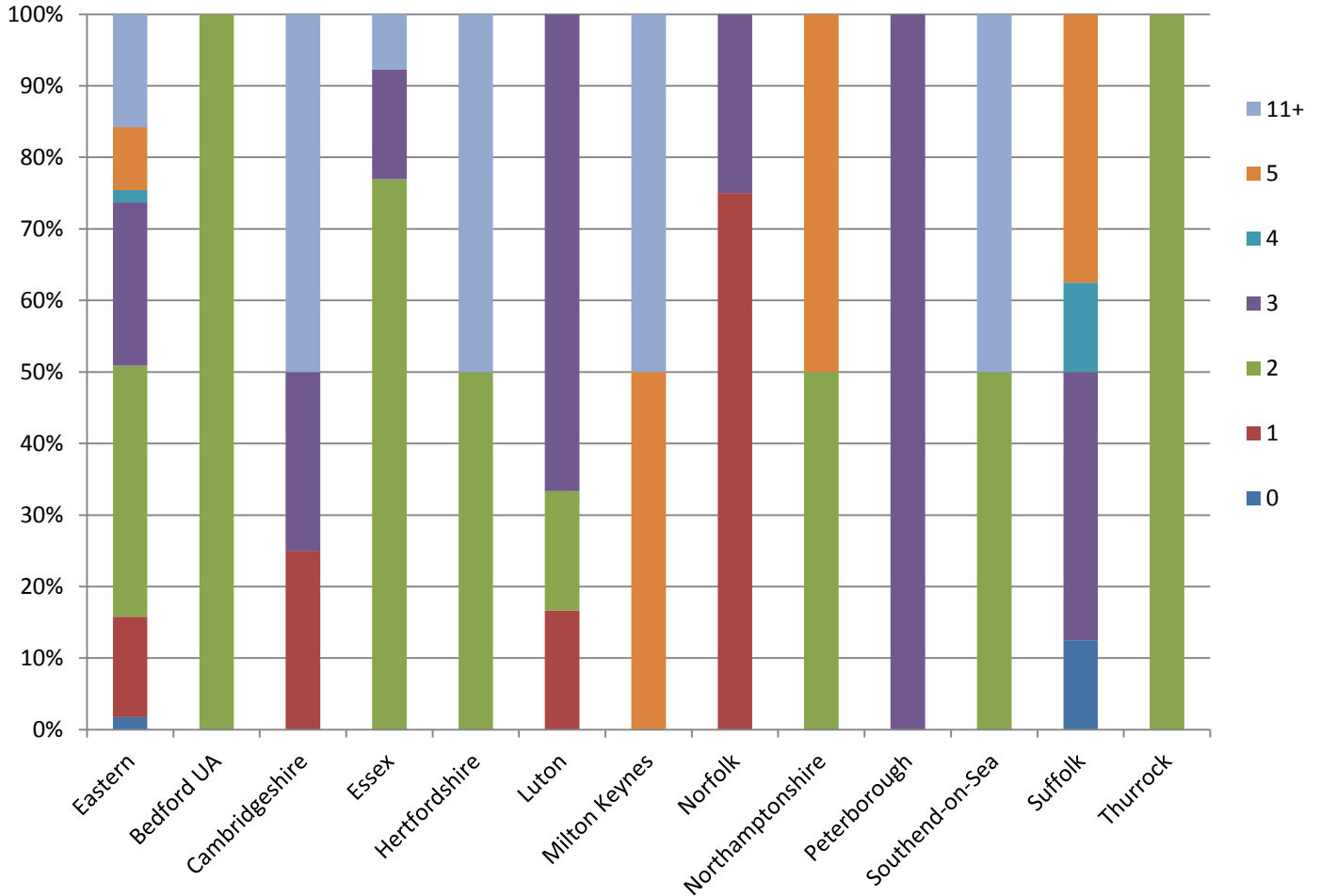


**Figure 13. Presence of a Business Continuity plan which incorporates a timetable for taking backups of NDTMS data** (please note, responses have been corrected for DET users where necessary)

Regionally, 63% of respondents have a timetable for data backups (including DET users).

Data entered on the DET is backed up nationally, overnight on a daily basis by the NDTMS central team. This may provide some reassurance to service managers using the DET. Those managers, however, might also consider that if their agency operates a “paperless” office policy, whereby paper forms get shredded after they are input, then the data input during the previous days may risk being lost forever. Such loss might occur if the central team’s backup processes were to fail or if they had to restore data back to an earlier point in time. Similar considerations may apply to users of other systems (although those users may have greater control over backup and restoration processes).

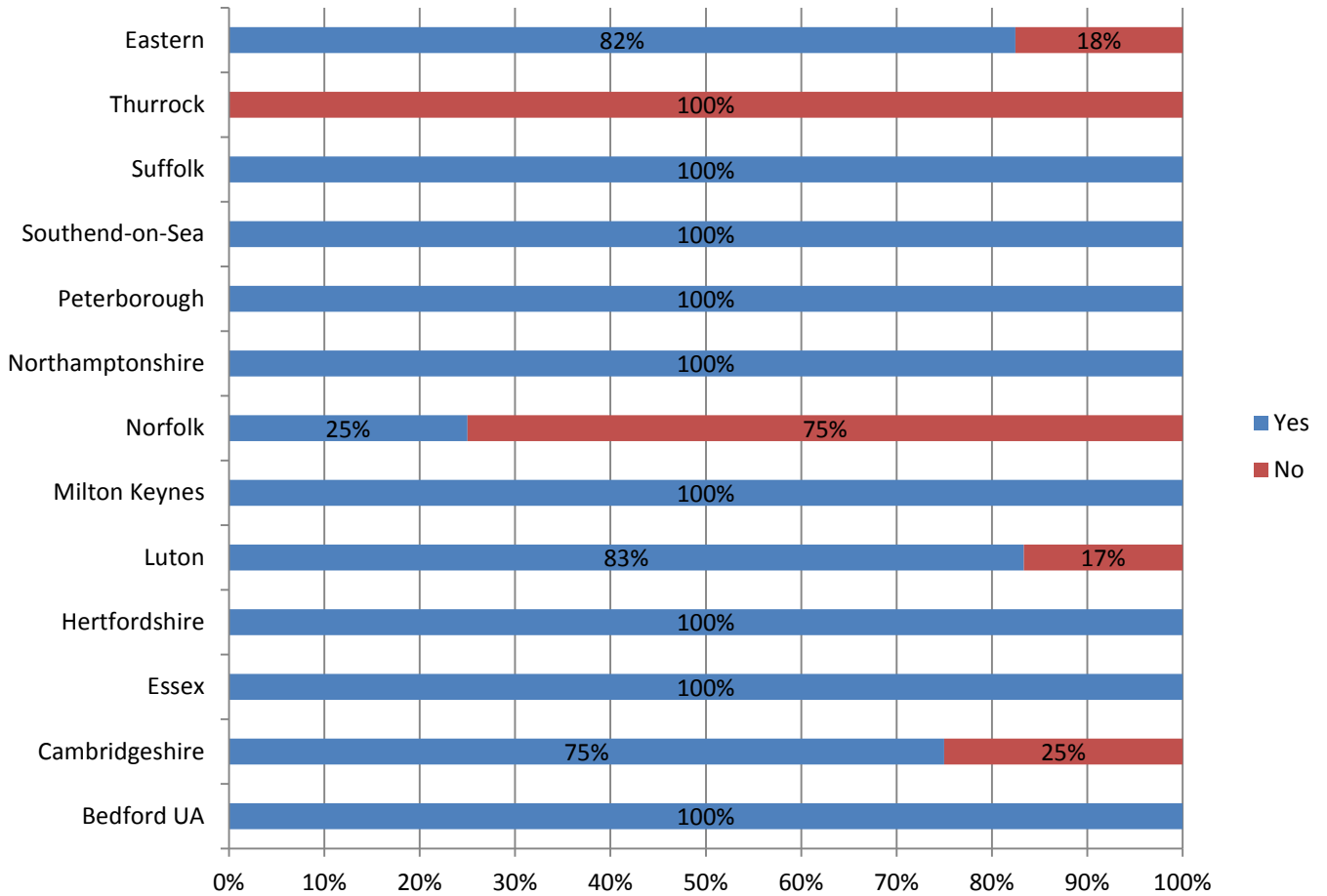
How many people in your organisation are expert system users whose role includes maintaining the NDTMS data extraction system and DAMS, or supporting other system users?



**Figure 13. Number of expert NDTMS system users per provider, for the Eastern region and by Partnership**

Figure 13 shows that 84% of providers regionally have at least two staff members responsible for NDTMS systems and 16% of providers only have one person (or less) responsible for NDTMS systems. This lack of resilience to cover systems in the case of staff sickness and leave means that NDTMS data may be at risk of non-submission from these providers.

Is your organisation able to continue to update and submit NDTMS data in the absence of the person(s) usually tasked with doing so?

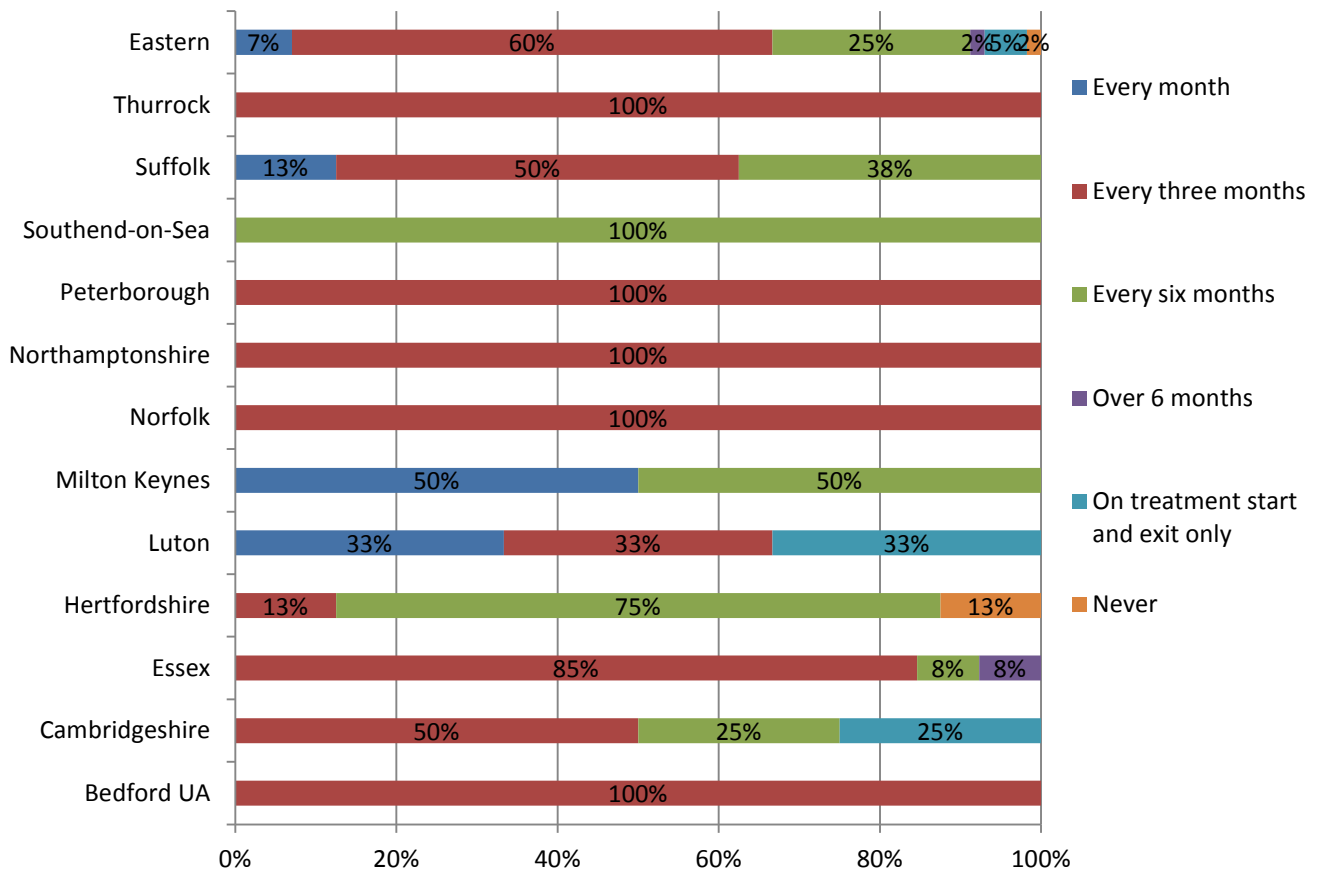


**Figure 14. Resilience of NDTMS submission in case of staff absence, for the Eastern region and by Partnership**

Of particular concern, 18% of respondents stated that in the absence of the person usually responsible for submitting their NDTMS data, they would not be able to continue to submit to NDTMS. As staff absence cannot always be anticipated this means that NDTMS is at risk of non submission from these providers.

# Frequency of reviews

Approximately how frequently does your organisation complete Sub Intervention Reviews?



**Figure 15. Frequency of Sub Intervention Review (SIR) completion, for the Eastern region and by Partnership**

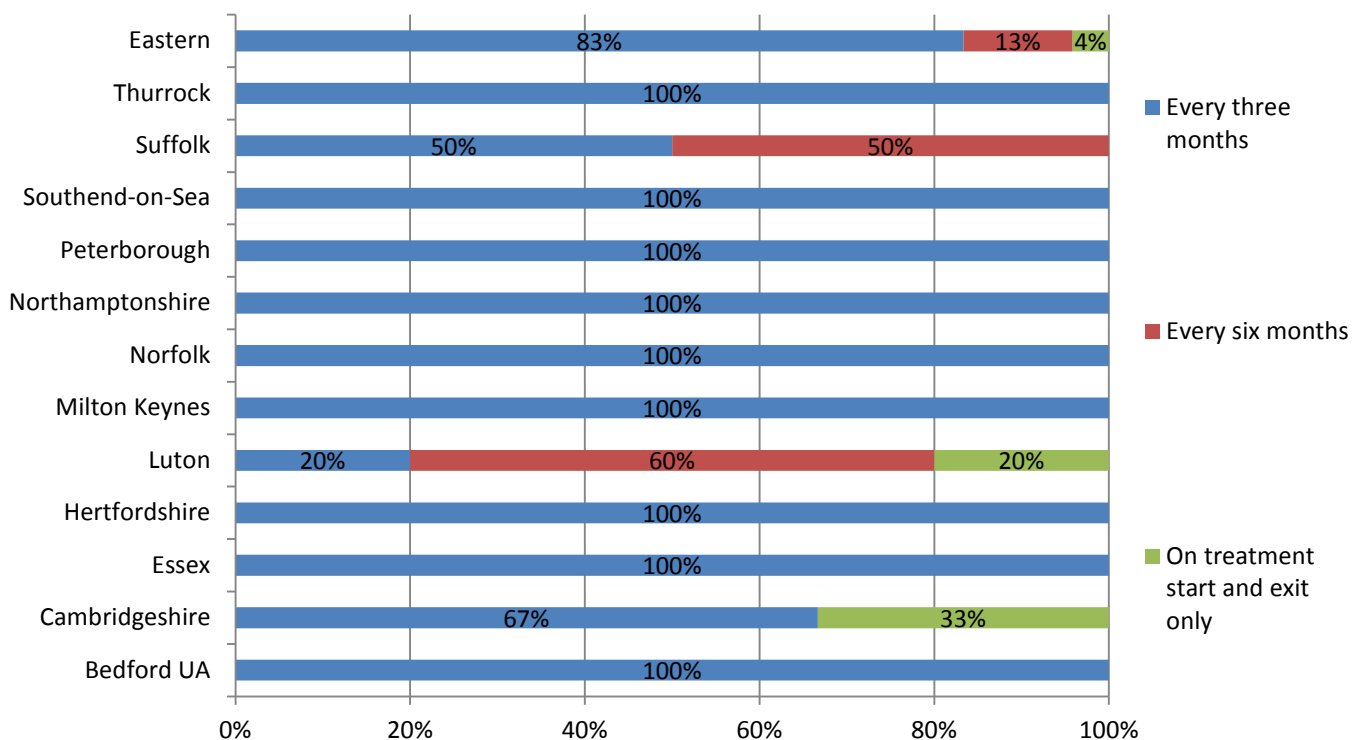
NDTMS guidance states that Sub Intervention Reviews should be completed at least every six months and/or at discharge, but facilitates more frequent reporting.

Figure 15 shows that regionally 92% of respondents complete SIRs at least every 6 months, and 67% complete them at least every 3 months. Two percent complete them less frequently than six monthly and 5% complete them on start and exit only. Two percent stated that they never report this information.

It should be noted that due to individual treatment system configuration, some services may not be completing SIRs due to arrangements for their completion by peer services.



## Approximately how frequently does your organisation complete TOP?



**Figure 16. Frequency of Treatment Outcome Profile (TOP) completion, for the Eastern region and by Partnership (n = 48)**

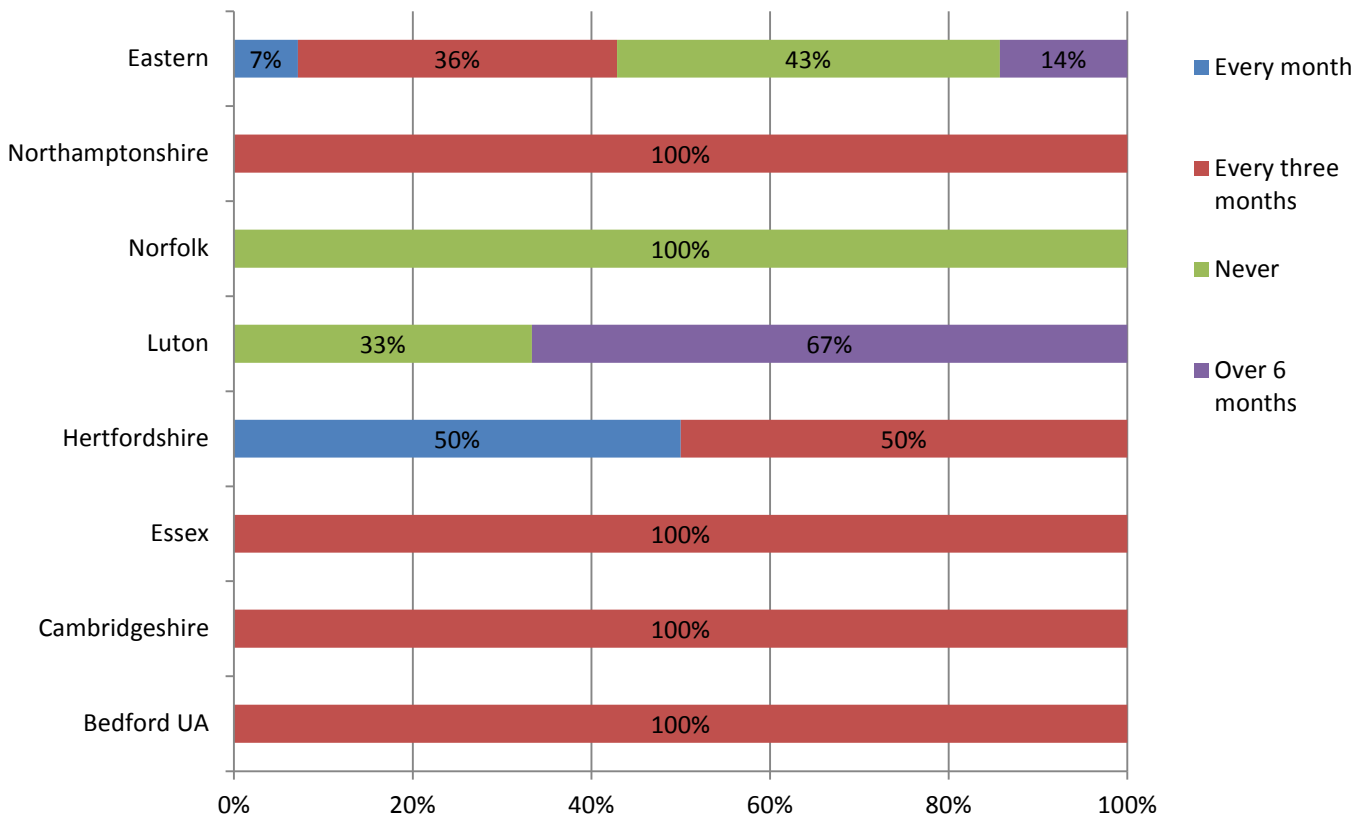
NDTMS guidance states that Treatment Outcome Profiles (TOPs) should be completed at least every six months but facilitates more frequent reporting.

Sixteen percent of respondents stated that TOP are not applicable for their service (suggesting they use AOR or YPOR instead).

Of those who do use TOP (n = 48), 96% stated that they complete them at least every six months whilst 83% reported that they submit TOPs at least every three months. Only Suffolk and Luton completes them six monthly. Four percent stated that they are completed on start and exit of treatment episodes only, these services are in Cambridgeshire and Luton.

It should be noted that due to individual treatment system configuration, some services may not be completing TOPs due to arrangements for their completion by peer services.

Approximately how frequently does your organisation complete AOR?



**Figure 17. Frequency of Alcohol Outcome Record (AOR) completion, for the Eastern region and by Partnership (n = 14)**

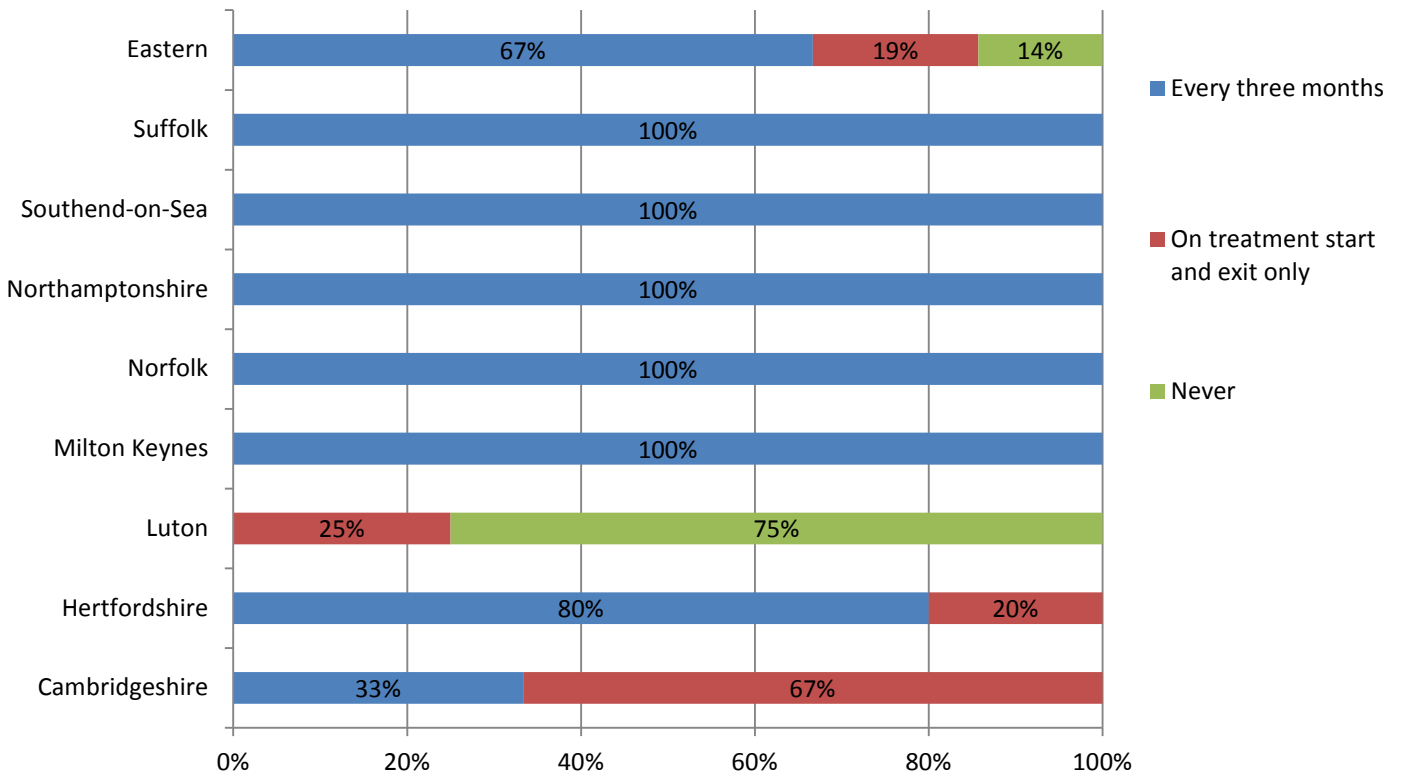
NDTMS guidance states that Alcohol Outcome Records (AORs) should be completed at treatment start and exit and more frequently if required. They are an option for adult clients whose primary problematic substance is alcohol, if TOP is not deemed to be appropriate.

Seventy two percent of respondents in the Eastern region stated that the AOR form is not applicable to them (suggesting that they use TOP or YPOR instead).

Of those who do use the AOR form (n = 14), 43% of services reported completing them at least every three months and 43% of services stated they never completed them.

It should be noted that due to individual treatment system configuration, some services may not be completing TOPs due to arrangements for their completion by peer services. Also, as appears to be the case in Norfolk where no services are recording their use, it is possible that some of these respondents should have selected “N/A” rather than “never”.

Approximately how frequently does your organisation complete YPOR?



**Figure 18. Frequency of Young Person Outcome Record (YPOR) completion, for the Eastern region and by Partnership (n = 21)**

NDTMS guidance states that Young Person Outcome Records (YPOR) should be completed at treatment start and exit, and more frequently if required.

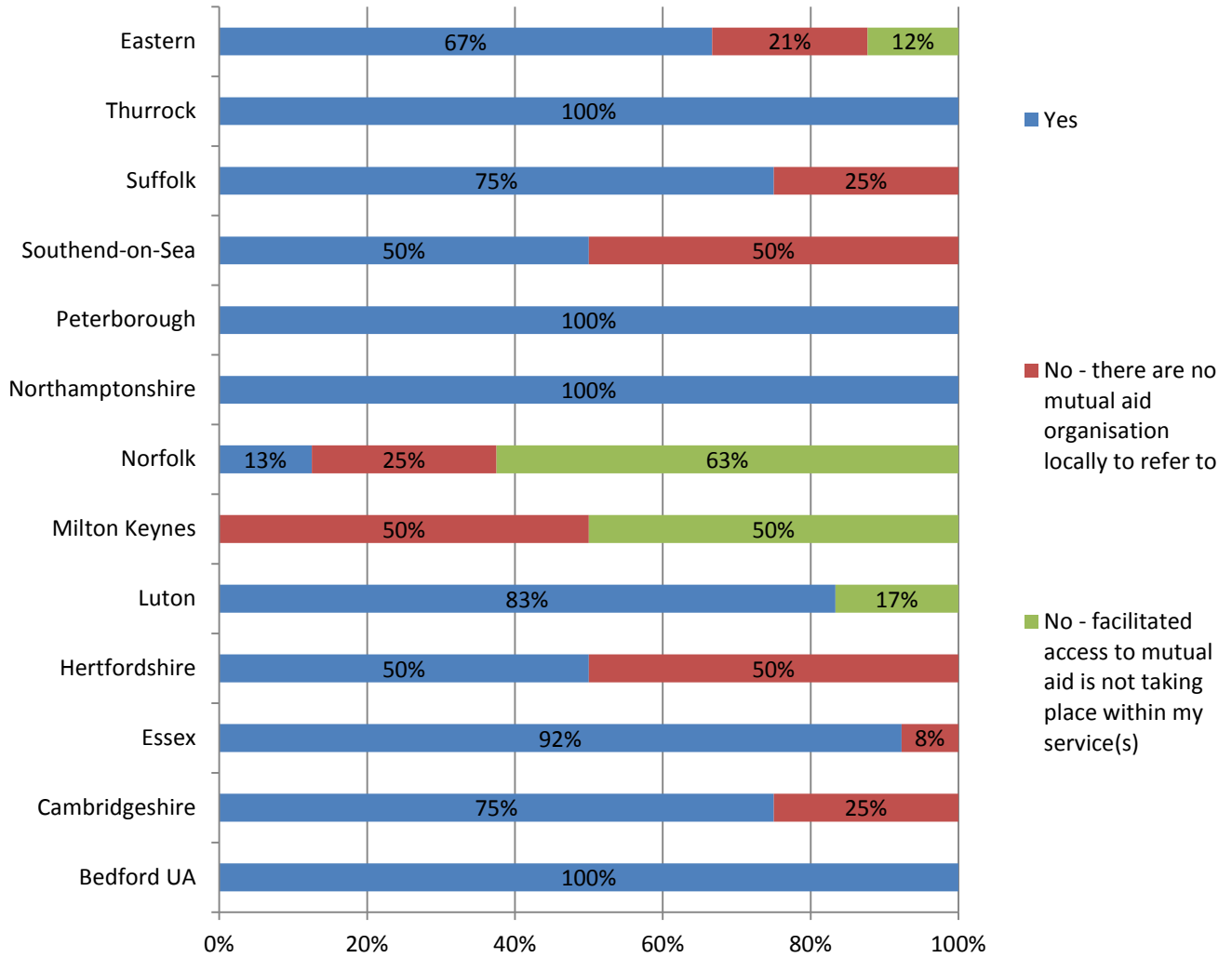
Seventy two percent of respondents from the Eastern region stated that the YPOR was not applicable to them (suggesting that they use TOP or AOR instead).

Of those who do use the YPOR (n = 21), 86% complete them at least at start and exit and 14% reported “never” completing them.

It is possible that some of these respondents in Luton who stated that they never completed YPOR should have selected “N/A” rather than “never”.

# Mutual aid referral

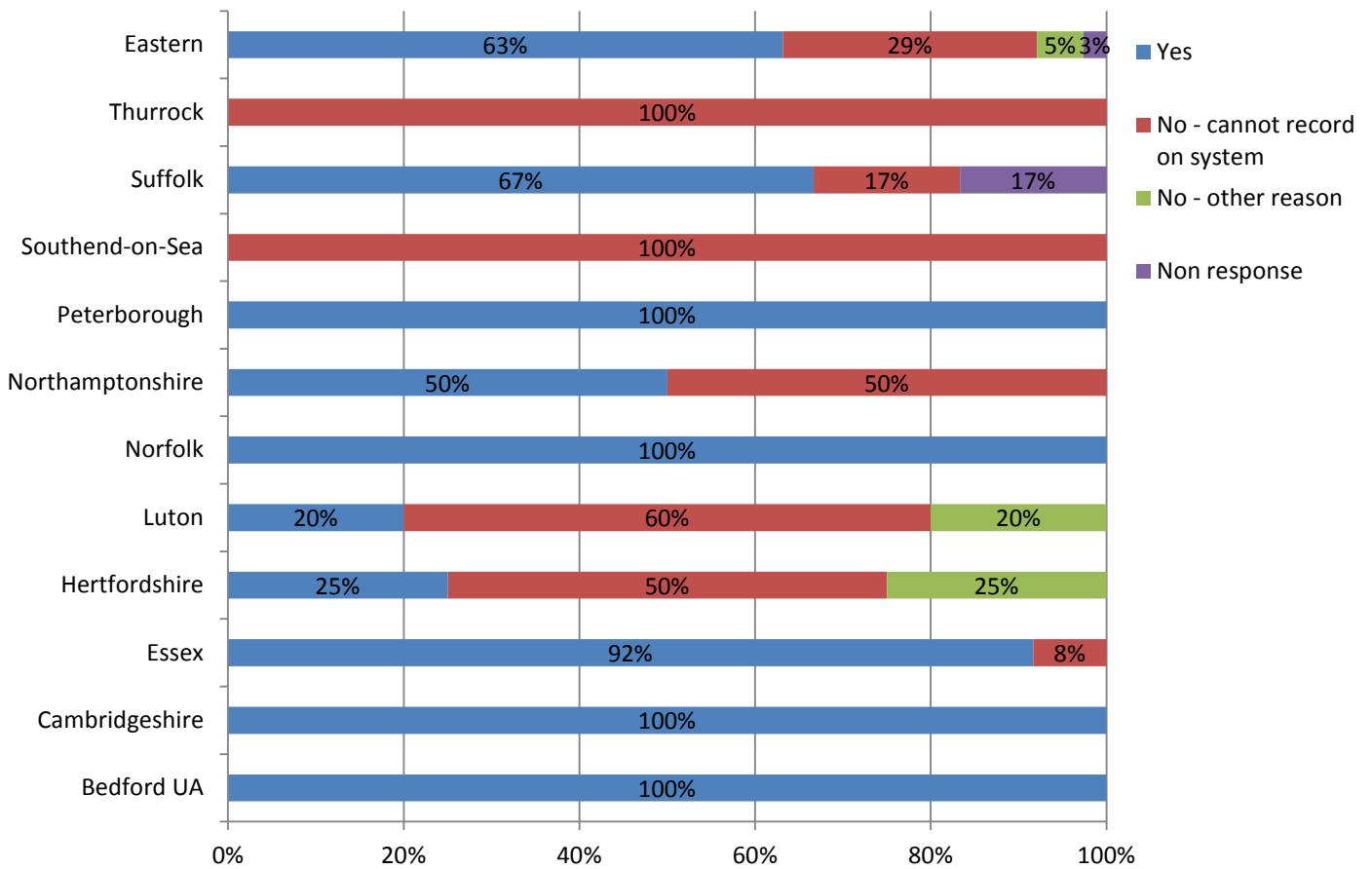
Do you refer clients to mutual aid organisations?



**Figure 19. Occurrence of mutual aid referral, for the Eastern region and by Partnership**

Regionally, 67% of services reported that they refer clients to mutual aid organisations (as illustrated in Figure 19). Twelve percent of respondents reported that they are not referring to mutual aid organisations and 21% reported that there were no mutual aid services to refer to locally.

### Do you record mutual aid referrals on NDTMS?



**Figure 20. Recording of mutual aid referrals on NDTMS systems, for the Eastern region and by Partnership (n = 38)**

Figure 20 shows that of those who do refer to mutual aid, 63% reported that they do record this on NDTMS systems. Of concern, 29% reported that they do not record mutual aid referrals on NDTMS systems as they are unable to do so.

It is possible that respondents misinterpreted this question and were referring to not being able to record the date and where the referral was made to, however, given that the numbers are so high this highlights a general training need which the NDTMS regional teams will look to address.

Given the priority applied to the national Drug Recovery agenda and the intrinsic part that mutual aid is expected to play, regional NDTMS teams will be prioritising discussions with those services who are unable to report this activity to provide support and guidance either to the service or to the system supplier as appropriate.

## Appendix 1.

**Table 3. Eastern agencies who completed the NDTMS provider survey 2014**

DAT area	Parent organisation	Agency
Bedford UA	South Essex Partnership University NHS Foundation Trust	Q1536 Enhanced Care Service
Cambridge	CRI	Q1709 CRI CSMHOT Alcohol Service
Cambridgeshire	Cambridgeshire DAAT	Q1640 Cambridgeshire Youth Offending Service
Cambridgeshire	Addaction	Q1668 Addaction Alcohol Treatment Service
Cambridgeshire	Cambridgeshire and Peterborough NHS Foundation Trust	Q1711 CASUS Cambridgeshire
Essex	Open Road	Q1423 Open Road Clacton
Essex	Open Road	Q1424 Open Road Colchester
Essex	North Essex Partnership NHS Foundation Trust	Q1425 NEEDAS
Essex	North Essex Partnership NHS Foundation Trust	Q1426 Changes
Essex	Open Road	Q1541 Open Road Mid-Essex
Essex	Phoenix Homes Colchester	Q1611 9 Oxford Road Alcohol Project
Essex	Synergy Addiction Treatment	Q1616 Synergy
Essex	Open Road	Q1642 Open Road Basildon
Essex	Open Road	Q1643 Open Road Brentwood
Essex	Open Road	Q1654 Open Road South East Essex
Essex	Open Road	Q1655 Open Road New Horizons
Essex	Open Road	Q1659 Open Road Chelmsford
Essex	Open Road	Q1660 Open Road Harlow
Hertfordshire	The Living Room	Q1407 The Living Room
Hertfordshire	Hertfordshire Partnership NHS Foundation Trust	Q1558 A-DASH
Hertfordshire	Resolve	Q1636 Resolve
Hertfordshire	The Living Room, St Albans	Q1700 The Living Room (St Albans)
Hertfordshire	CRI	Q1684 CRI Hertfordshire Drug and Alcohol Recovery Services - Cluster A (North)
Hertfordshire	CRI	Q1685 CRI Hertfordshire Drug and Alcohol Recovery Services - Cluster B (East)
Hertfordshire	CRI	Q1686 CRI Hertfordshire Drug and Alcohol Recovery Services - Cluster C (South)
Hertfordshire	CRI	Q1687 CRI Hertfordshire Drug and Alcohol Recovery Services - Cluster D (West)
Luton	South Essex Partnership University NHS Foundation Trust	Q1043 LDASS
Luton	South Essex Partnership University NHS Foundation Trust	Q1413 Probation DTTO Luton
Luton	Luton Teaching PCT	Q1493 Shared Care Drug Service
Luton	TTP	Q1595 Trust The Process Counselling - Luton

Luton	Stonham	Q1602 Stonham (Hope House)
Luton	Luton Youth Offending Service	Q1673 Luton Youth Offending Service
Milton Keynes	Compass	P0802 Compass Milton Keynes Young Persons
Milton Keynes	CRI	P1014 CRI Milton Keynes Recovery Service
Norfolk	Hebron Trust	Q1311 Hebron Trust
Norfolk	Norfolk County Council	Q1577 Norfolk Youth Offending Team
Norfolk	The Matthew Project	Q1657 The Matthew Project Under 18 Service
Norfolk	Norfolk Recovery Partnership (NRP)	Q1702 Norfolk Recovery Partnership (NRP) - Central
Norfolk	Norfolk Recovery Partnership (NRP)	Q1703 Norfolk Recovery Partnership (NRP) - East
Norfolk	Norfolk Recovery Partnership (NRP)	Q1704 Norfolk Recovery Partnership (NRP) - West
Norfolk	Norfolk Recovery Partnership (NRP)	Q1705 Norfolk Recovery Partnership (NRP) - South
Norfolk	Norfolk Recovery Partnership (NRP)	Q1706 Norfolk Recovery Partnership (NRP) - North
Northamptonshire	Council on Addiction	T1058 CAN Young Peoples
Northamptonshire	CRI	T1182 CRI Northants
Peterborough	CRI	Q1682 CRI Peterborough Recovery Service
Southend-on-Sea	Southend-on-Sea Borough Council	Q1568 Southend Young People Substance Misuse Service
Southend-on-sea	CRI	Q1617 CRI Southend
Suffolk	Norcas	Q1010 Norcas - ipswich
Suffolk	East Coast Recovery Limited	Q1652 East Coast Recovery Limited
Suffolk	Norfolk & Suffolk NHS Trust	Q1667 Suffolk Alcohol Treatment Service
Suffolk	The Matthew Project	Q1671 Under18 Suffolk Outreach
Suffolk	The Matthew Project	Q1672 Under18 Suffolk Criminal Justice
Suffolk	CRI	Q1676 CRI Bury St Edmunds
Suffolk	CRI	Q1677 CRI Lowestoft
Suffolk	CRI	Q1678 CRI Ipswich
Thurrock	Open Door	Q1549 Oasis Open Door
Thurrock	Open Door	Q1569 TYPDAS (Thurrock Young Persons Drug and Alcohol Service)