Public Health England

Protecting and improving the nation's health

2014-15 Alcohol and Drugs Treatment Commissioning Tool: Guidance document

Contents

Introduction

The Commissioning Tool is one way in which we are helping Local Authorities (LAs) understand and improve the value for money of structured treatment. The Tool comprises:

- a local cost-effectiveness analysis (CEA)
- a cost calculator

The calculator helps commissioners estimate their spend on drug and alcohol structured and non-structured treatment for use in the commissioning tool and other value for money product. The CEA component can help explain why certain pathway/ demographic combinations vary in cost-effectiveness.

Throughout 2015, commissioners submitted their financial data through the 2013-14 Cost Calculator to help us calculate benchmarked spend data. 22% of LAs submitted their data, meaning that we have only been able to provide indicative national benchmarked data at this time. Below is a table reporting the returns for each PHE centre:

PHE Region	% submissions
North East	0%
Yorkshire and the Humber	47%
North West	0%
East Midlands	22%
West Midlands	43%
East of England	14%
South East	6%
South West	31%
London	33%
National	**22%**

For LAs that submitted their 2013-14 financial information, this data has been inflated to 2014-15 prices and prefilled automatically in the Commissioning Tool so commissioners can start to explore the cost-effectiveness of treatment in their area immediately. If however, areas have more up-to-date financial information and wish to amend the expenditure data, they are able to do so.

We would be grateful if any updates or entries of spend data could be sent to us via the submit buttons included in the Tool. This will enable us to provide better benchmarked data in future and to have better estimates of national unit costs.

Also, we would like to remind you that the Tool is not a national performance management tool. It has been specifically designed for local use only and data submitted to us will not be shared externally.

We are committed to making sure this Tool has real world utility. That is why we are very keen to receive your feedback about how we can improve the Tool so that it is as relevant as possible. If you do have any feedback please do send it to us at HealthEconomics@phe.gov.uk.

Getting started

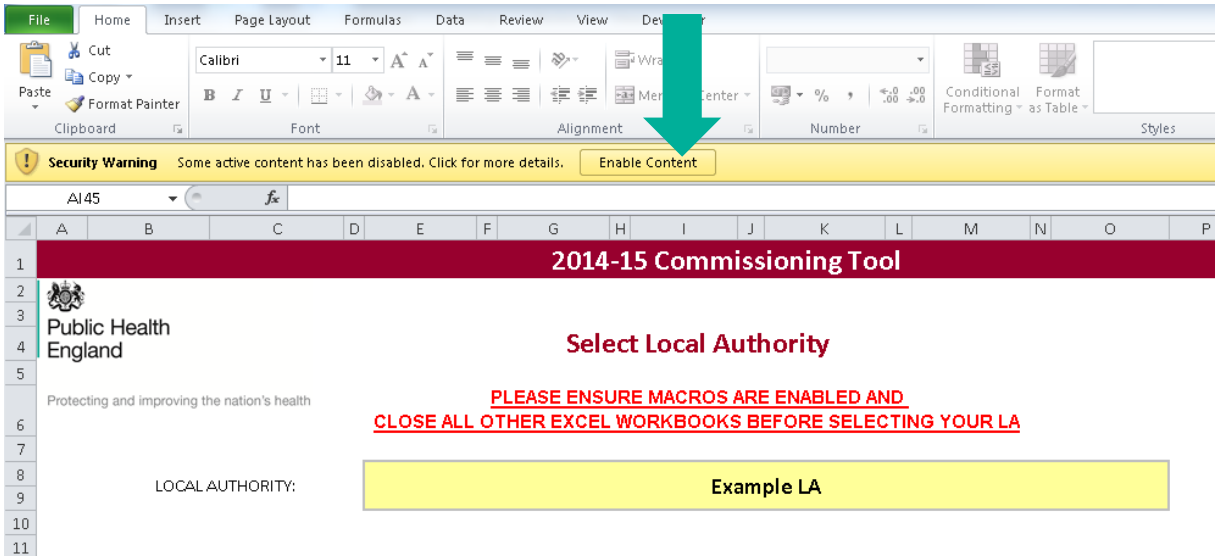
Before starting, **ensure macros are enabled** by clicking 'Enable content' on the yellow bar at the top of the sheet, or in the popup box that appears when first opening the Excel file. **Closing other Excel applications and workbooks** will also reduce the possibility of errors occurring in background macros and calculations, and make the Tool run faster.

The Tool is password protected so that alcohol and drug commissioners (and the people they authorise) can view only their LA's data. It is not possible to view data from other LAs. Select your LA from the drop down box and type in your LA's VfM password (formerly TOP password).

If you do not know your password, please contact HealthEconomics@phe.gov.uk. For training and sharing purposes, we have created an Example LA. To view, you can select 'Example LA' from the bottom of the drop down list, and type in 'password' when requested to provide a password.

Once you have correctly entered your password, the introduction tab will open, providing an overview of the Tool.

Figure 1: Opening the Tool



Costs

This section reports the cost data that are the basis of the cost-effectiveness analysis (CEA). Costs are broken down by spend on (1) drugs and (2) alcohol only clients separately, and by four mutually exclusive high-level interventions/ settings: (1) community pharmacological, (2) community psychosocial, (3) inpatient detoxification and (4) residential rehabilitation.

Inpatient and residential rehabilitation are settings in which pharmacological and/or psychosocial interventions could take place, but have been aggregated for costs and analysis purposes to better reflect the way services are commissioned and therefore the type of expenditure information commissioners are more likely to have at their disposal.

Users must select or enter unit costs for the CEA to work. Areas that submitted their unit costs to us via the 2013-14 Cost Calculator will note that the Tool is prepopulated with their data, inflated to 2014-15 prices. If necessary, these can be overwritten**.** The options are:

1. Submitted LA specific 2013-14 Cost Calculator unit costs inflated to 2014-15 (if available)
2. Estimating 2014-15 unit costs using the updated Cost Calculator in section 2 of the tool

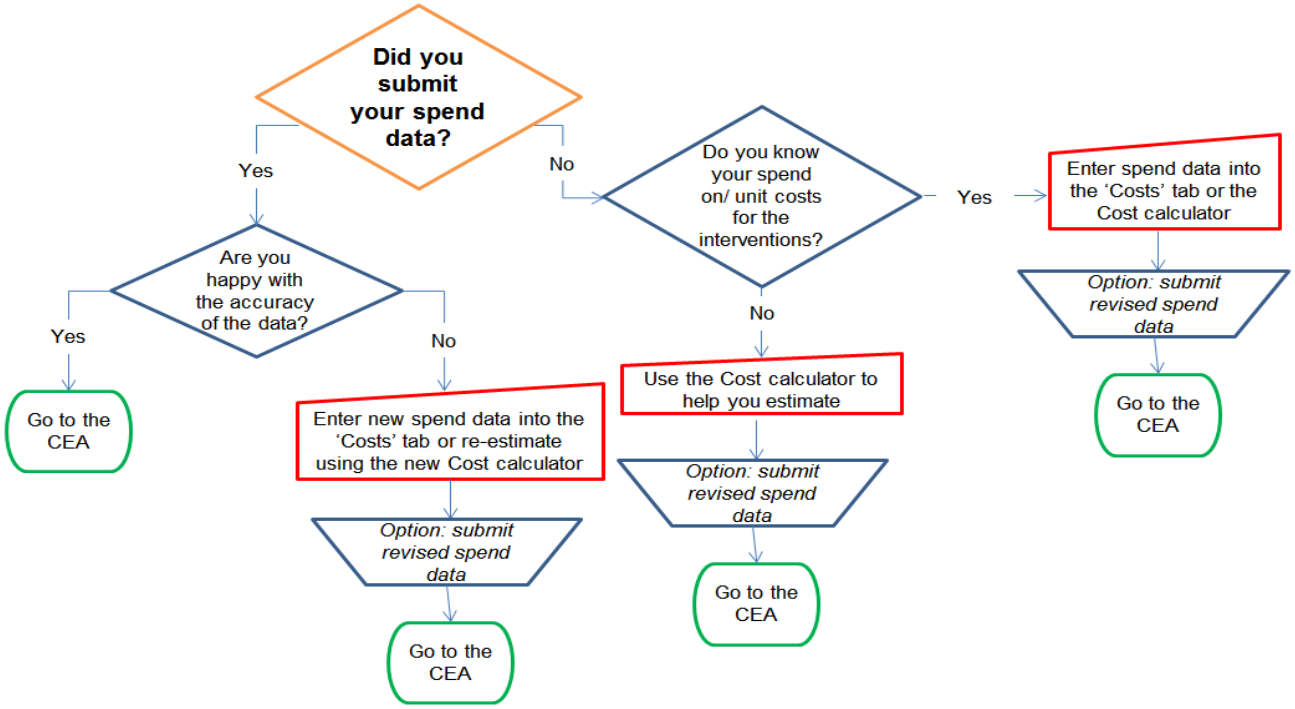
Also displayed are average unit costs taken from submissions (22%; inflated to 2014-15 and adjusted for local market forces) and published national unit costs (inflated to 2014-15 and adjusted for local market forces) for information. Areas can use these costs to explore how cost-effectiveness changes in their area when different reasonable estimates of cost are used.

A manual entry can be made in the yellow box for each intervention/ setting. Any value in the yellow boxes will flow through to the calculation of costs and subsequently the CEA of each intervention pathway for each LA. **In order to improve our benchmarked data in future iterations, we would encourage all areas to submit their financial data to us. Local data will not be shared externally.**

Buttons below each column will also help prefill the yellow boxes from the cost calculator spend amounts, take you to the cost calculator to review and edit your calculated unit costs, or to reset the selected costs used in the CEA to those in the cost calculator.

The below flow chart illustrates how to estimate the unit costs of your LA using the Tool.

Figure 2: Cost options



If you do not have your spend data to hand, you can use national averages as a proxy, which we have adjusted to reflect market forces in your area

Sections 1a-1c: the cost-effectiveness analysis (CEA)

The CEA component of the Commissioning Tool allows users to help answer the following types of questions:

- Which combinations of treatment interventions appear to be the most cost-effective for different types of clients?
- Can we improve the cost-effectiveness of commissioned services?
- Can we use existing resources differently?

The data is presented by opiate users, non-opiate users[1] and alcohol only clients to reflect the different profiles and complexities of these groups. Opiate users are further segmented into 'all', 'new' and 'existing', due to their longer treatment journeys[2].

Non-opiate users tend to have much shorter treatment journeys and therefore it is not necessary to segment this population into new and existing. Alcohol only clients are allocated

[1] Opiate and non-opiate drug using clients may have alcohol cited as a problematic substance in their NDTMS record.

[2] Opiate using clients who have been in treatment for many years have the most entrenched drug use and therefore have a reduced likelihood of completing treatment in a given year. Segmenting the opiate population allows users of the tool to assess the effectiveness of treatment for opiate users who have entered treatment recently (defined as within the past two years) and for who, in the main, better outcomes would be expected.

according to the units consumed at the start of treatment. Breaking down data in this way helps ensure, as much as possible, that any CEA comparisons are like-for-like.

Pathway: Clients are grouped according to the combination of interventions / settings they received – up to four – either concurrently or at different stages of the treatment journey.

Benchmark: a comparative average based on the expected performance of areas of similar complexity profiles to the selected LA. Adjusting by complexity of population enables local areas to compare against a benchmark which is more attuned to the complexity of their population than the crude national rate. This type of benchmarking is only applicable to opiate and non-opiate users. Benchmarking for alcohol only clients is a national average based on levels of consumption at the start of treatment.

1a. CEA – Summary

From the summary tab, users can get an overview of the effectiveness of their treatment system. This section presents high-level CEA graphs for the most populous 5 pathways for successfully completing opiate, non-opiate and alcohol-only clients.

1b. CEA – Drugs Tx and 1c. CEA – Alcohol Tx

The drugs section comprises two tables: opiate users and non-opiate users. A drop down box in cell C5 allows users to see data on 'all', 'new' or 'existing' opiate clients. **Please note that information for non-opiate clients will only appear if 'All (new + existing)' is selected.**

Data on alcohol only (1c. CEA) clients is broken down into five drinking group categories, determined by the typical number of units consumed on a drinking day in the 28 days prior to initial assessment.

1. Lower level drinker/abstinent: 0 to 15 units
2. Middle level drinker: 16-30 units
3. Higher level drinker: greater than 31 units
4. Middle/ higher level drinker with complex needs: greater than 15 units with coexisting mental health needs, urgent housing needs, and/or benzodiazepine use
5. Units not recorded[3] (this is not represented in the graph in 1a. CEA – Summary)

The tables are arranged by the most common intervention and/or settings pathways and are based on the number of clients on each pathway within the 2014-15 financial year. Below are short explanations of the main data items:

No. in treatment: the number of clients on the treatment pathway in the 2014/15 financial year.

Average days in treatment: total days / number on pathway,flagged red if higher than the benchmarked average, green if lower, amber if similar.

Successful completions: the number of drug/alcohol users that left treatment successfully (free of substance of dependence), flagged red if lower than the benchmarked average, green if higher, amber if similar.

[3] The 'Lower level drinker', 'Middle/ higher level drinker with complex needs' and 'Units not recorded' include coexisting dual diagnosis, urgent housing need, and/or benzodiazepine use. The 'Middle level drinker' and 'Higher level drinker' categories do not.

Total spend in 2014-15: this is the cost of the sum of total individual pathway days using the unit costs entered on the *'Costs'* sheet for each LA.

Spend per client in treatment: the total spend divided by the number of clients in treatment, flagged red if higher than the benchmarked average, green if lower, amber if similar.

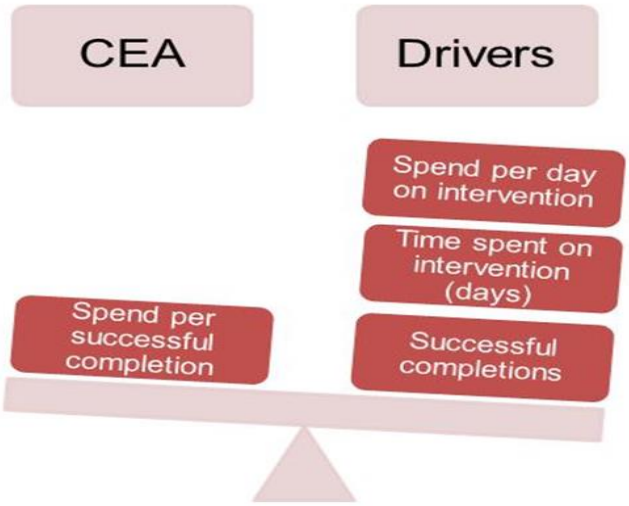
Spend per successful client: the total spend divided by the number of successful completions, flagged red if higher than the benchmarked average, green if lower, amber if similar.

Pharmacological, Psychosocial and Recovery Support columns: these figures are the percentage of clients that are on each sub-intervention.

Guide to interpretation

Cost-effectiveness is defined here as the spend per successful completion. When interrogating data, remember that three factors affect the cost-effectiveness of local treatment pathways: spend per day, days in treatment and the proportion of people successfully completing treatment.

Figure 3: Drivers of cost-effectiveness



Using the Commissioning Tool, there are two ways to make cost-effectiveness comparisons.

1. Comparing different treatment pathways within an LA
2. Comparing treatment pathways against a benchmark.

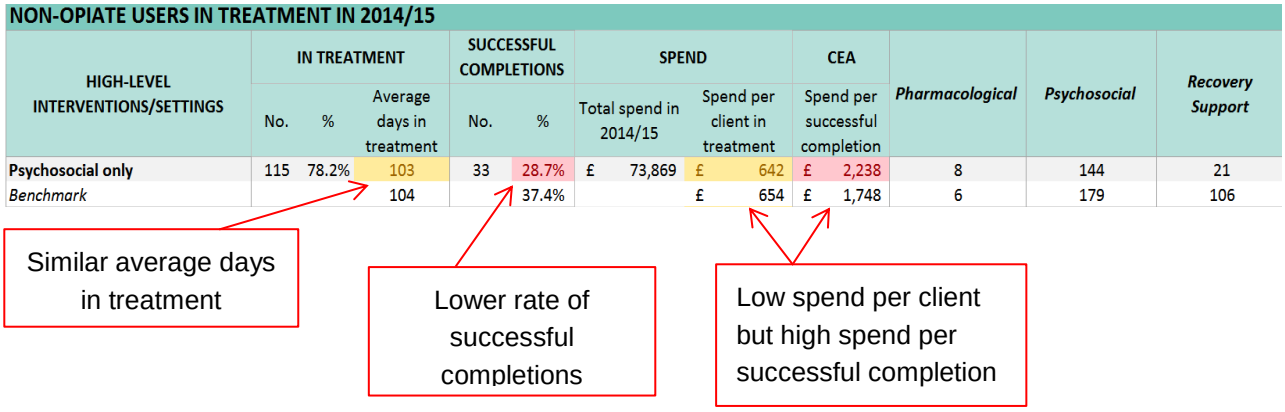
Comparing different treatment pathways within an LA

Below is an example of data from a hypothetical LA. It shows non-opiate clients in treatment during 2014/15. Most non-opiate clients in this LA received 'psychosocial only' (78.2%). Given the three drivers of cost-effectiveness (figure 3), commissioners should pay particular attention to the average days, estimated spend per client (as well as unit costs in the Costs tab) and the proportion of successful completions in the CEA tables.

The table shows that compared to what would be expected (based on the LA's characteristics), the 'psychosocial only' pathway is not as cost-effective in this LA as what is seen in the comparative benchmark (£2,249 vs. £1,757).

The Example LA had similar average days in treatment and spend per client than the benchmark so these cannot be a contributory factor to the result. However, the LA is not achieving the rate of successful completions it is estimated it could achieve. To improve its cost-effectiveness, this LA could explore why successful completions for people on this pathway are not as high as they could be.

Figure 4: Comparing different treatment pathways within an LA



NON-OPIATE USERS IN TREATMENT IN 2014/15												
HIGH-LEVEL INTERVENTIONS/SETTINGS	IN TREATMENT			SUCCESSFUL COMPLETIONS		SPEND		CEA	*Pharmacological*	*Psychosocial*	*Recovery Support*
	No.	%	Average days in treatment	No.	%	Total spend in 2014/15	Spend per client in treatment	Spend per successful completion			
Psychosocial only	115	78.2%	103	33	28.7%	£ 73,869	£ 642	£ 2,238	8	144	21
Benchmark			104		37.4%		£ 654	£ 1,748	6	179	106

Comparing treatment pathways against a benchmark

The CEA section can also be used to check the cost-effectiveness of different interventions. Figure 5 below shows data for 'psychosocial only' and the second most populous pathway for non-opiates in Example LA: 'pharmacological and psychosocial'. In this latter example, despite people being in treatment for longer, the average spend and overall cost-effectiveness is
better than would be expected based on the LA characteristics.

Figure 5: Comparing different treatment pathways against a benchmark

NON-OPIATE USERS IN TREATMENT IN 2014/15											
HIGH-LEVEL INTERVENTIONS/SETTINGS	IN TREATMENT			SUCCESSFUL COMPLETIONS		SPEND		CEA	*Pharmacological*	*Psychosocial*	*Recovery Support*
	No.	%	Average days in treatment	No.	%	Total spend in 2014/15	Spend per client in treatment	Spend per successful completion			
Psychosocial only	115	78.2%	103	33	28.7%	£ 73,869	£ 642	£ 2,238	8	144	21
Benchmark			104		37.4%		£ 654	£ 1,748	6	179	106
Pharmacological & Psychosocial	24	16.3%	186	7	29.2%	£ 50,504	£ 2,104	£ 7,215	29	38	5
Benchmark			172		29.2%		£ 2,263	£ 7,759	31	47	32

Looking at the spend and outcomes for different pathways for non-opiate clients, an initial comparison of 'psychosocial only' with 'pharmacological and psychosocial' might suggest the latter to be less cost-effective (£2,238 vs £7,215).

However, it is important to remember that the interventions delivered are dependent on the clinical needs of the client, e.g. some people using non-opiates may need additional pharmacological interventions resulting in the total cost of delivering this pathway to be more expensive. When making these comparisons it is sensible to consider what proportion of individuals are using this pathway and how this compares to the national average, as well as the spend and outcomes achieved.

In the example above, while 'pharmacological and psychosocial' seems a more costly pathway, it compares favourably to the to the benchmarked average and as such the

pathway could be considered as achieving better than would be expected given the complexities of the clients and so may not warrant any further investigation.

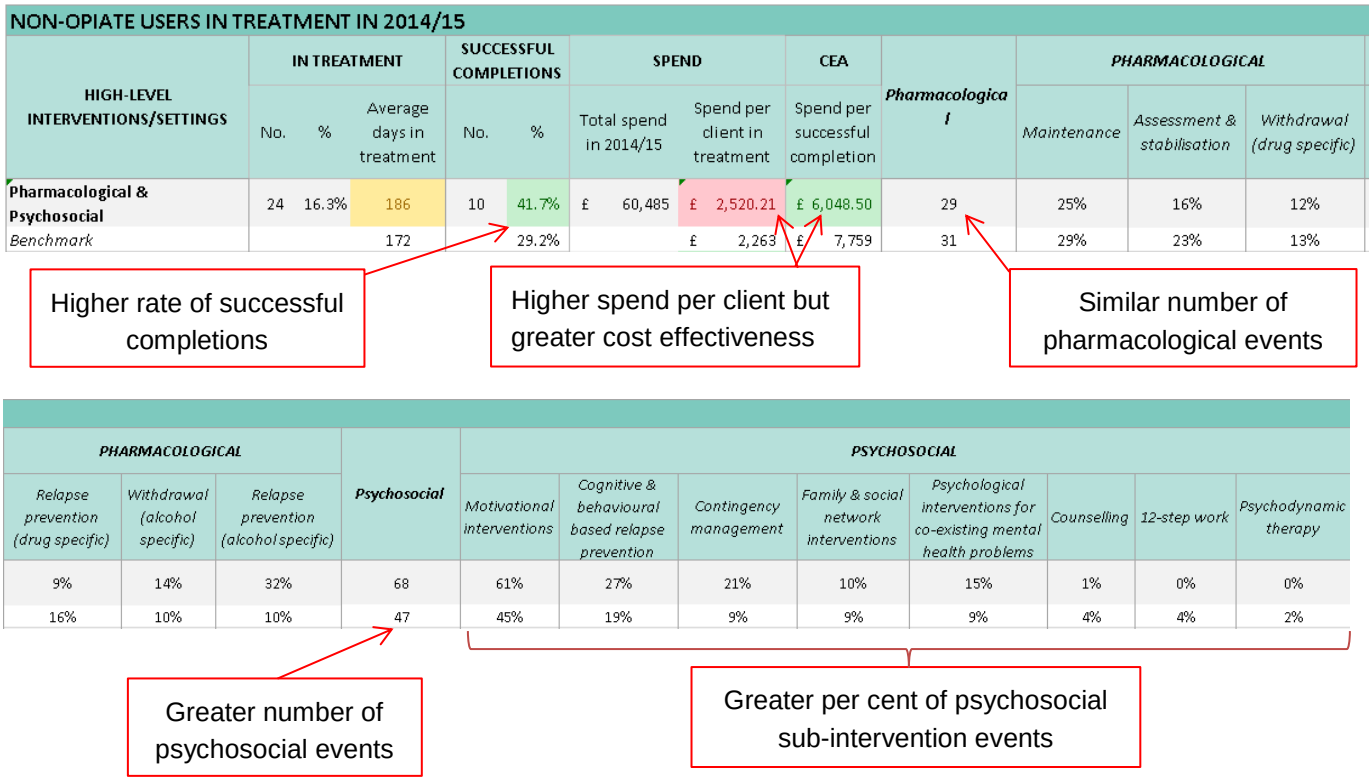
If, however, a pathway compares unfavourably with the benchmarked group, or a higher proportion of people accessed more expensive pathways than the national average, then this investigation could help ensure that future interventions provided are relatively more effective, cost-effective and appropriate for the client.

Interpreting the sub-interventions data

When considering the expenditure and outcomes on an individual pathway it is advised that the sub-interventions that have been provided on that pathway are also considered. Where a significantly higher or lower proportion of sub-interventions have been delivered compared to the benchmark then this may be impacting on expenditure, causing the pathway to seem more or less expensive than areas with similar complexities.

Alongside this, the delivery (or not) of sub-interventions may be a contributory factor in the achievement of successful completion outcomes. The range of sub-interventions provided on a pathway can be reviewed to see how the breadth and proportions compare to what is being delivered in similar areas and subsequent outcomes.

Figure 6: Sub-interventions



NON-OPIATE USERS IN TREATMENT IN 2014/15

HIGH-LEVEL INTERVENTIONS/SETTINGS	IN TREATMENT			SUCCESSFUL COMPLETIONS		SPEND		CEA	Pharmacological	PHARMACOLOGICAL		
	No.	%	Average days in treatment	No.	%	Total spend in 2014/15	Spend per client in treatment	Spend per successful completion		Maintenance	Assessment & stabilisation	Withdrawal (drug specific)
Pharmacological & Psychosocial	24	16.3%	186	10	41.7%	£ 60,485	£ 2,520.21	£ 6,048.50	29	25%	16%	12%
Benchmark			172		29.2%		£ 2,263	£ 7,759	31	29%	23%	13%

Higher rate of successful completions

Higher spend per client but greater cost effectiveness

Similar number of pharmacological events

PHARMACOLOGICAL			Psychosocial	PSYCHOSOCIAL							
Relapse prevention (drug specific)	Withdrawal (alcohol specific)	Relapse prevention (alcohol specific)		Motivational interventions	Cognitive & behavioural based relapse prevention	Contingency management	Family & social network interventions	Psychological interventions for co-existing mental health problems	Counselling	12-step work	Psychodynamic therapy
9%	14%	32%	68	61%	27%	21%	10%	15%	1%	0%	0%
16%	10%	10%	47	45%	19%	9%	9%	9%	4%	4%	2%

Greater number of psychosocial events

Greater per cent of psychosocial sub-intervention events

Improving cost-effectiveness

The Commissioning Tool does not provide definitive answers; the CEA results do not offer an argument to stop investing in interventions with relatively higher spend, or encourage further investment in those with comparatively lower costs. Commissioners should therefore use the Tool to explore potential ways to improve cost-effectiveness in the future as well as possible

reasons for any anomalies in the data (e.g. incorrect recording of expenditure or NDTMS interventions data).

1. Improving data recording

Inaccurate recording of local activity affects unit costs and expenditure data. If money is spent on an intervention, but fewer clients are recorded as receiving it than actually did so, then local spend will appear much higher than it is in reality. It is also important that providers correctly report on NDTMS when clients stop accessing their services: time in treatment is an important factor in the cost-effectiveness calculations.

2. Reducing the unit costs of treatment

There are several means by which commissioners may seek to reduce unit costs, if deemed necessary, which will depend on local circumstances and involve collaboration with providers. It is important to collectively consider the impact of any changes. For example, it would be incongruous if unit costs were significantly reduced so as to have a negative impact on other outcomes or process measures, such as waiting times, drug related deaths or blood borne virus vaccination, treatment or transmission rates.

Bearing that in mind, a few considerations are listed below. Commissioners could:

- explore with providers the possible drivers of high unit costs
- consider how and where better use of mainstream provision (e.g. housing, employment), could support service delivery and the achievement of improved outcomes
- consider provider contract revisions to increase the focus on outcomes

3. Ensuring clients are in treatment for an appropriate length of time and help more people recover from their dependency

Being in structured treatment has immediate benefits. Some people need to be in treatment for a long time; a premature cessation of their treatment may result in relapse. Others require a shorter treatment span; keeping such clients for longer than necessary is a waste of resources and may impede recovery.

Improving the recovery-orientation of treatment is a wide-ranging exercise but can involve the following key elements:

- Understanding the local treatment population and targeting active recovery more at those ready for it
- Protecting (and continuing to offer recovery opportunities to) those with an enduring treatment need
- Ensuring treatment and recovery journeys are dynamic for all: planned then continually reviewed and optimised
- Facilitating service users to engage with mutual aid can add value by increasing and sustaining the gains achieved by formal treatment[4]. By doing so, the cost-effectiveness is likely to be high, especially given the negligible financial outlay required for an increase in successful completions. Developing other asset-based resources to support drug and alcohol recovery (e.g. peer mentoring) is likely to have a similar positive effect.
- Involving service users, families and broader recovery communities so that recovery is creatively and broadly supported, as well as highly visible

[4] A briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid www.nta.nhs.uk/uploads/mutualaid-briefing.pdf

- Integrating pathways across health and social care, criminal justice, employment, housing, recovery support, etc.
- Using data – especially on outcomes – astutely, clinically and managerially with clients, with staff, managers, and commissioners

Useful resources

Medications in Recovery: Re-orientating drug dependence treatment sets out practical steps to meet the 2010 Drug Strategy commitment that all those on substitute prescriptions should engage in recovery activities.
http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

The *Recovery Diagnostic Toolkit* can help to understand how changes in the profile of local treatment populations compare within cluster groups or nationally, as well as how well locally each of the different client groups are doing in terms of achieving outcomes during treatment and also in completing successfully free of dependency www.ndtms.net

JSNA support pack for commissioners outlines key principles that local areas might consider when developing plans for an integrated recovery system. There are five principles, followed by a series of prompts to help put them into practice http://www.nta.nhs.uk/healthcare-JSNA.aspx

Recovery Resources is an online library on substance misuse treatment that can be used to support and improve the interventions provided in purposeful treatment journeys.
www.nta.nhs.uk/recovery-resources.aspx

Sections 2a-2c: the 2014-15 Cost Calculator

The government has identified 4 key principles that drive value for money and improve the services provided to the public:

i. Transparency – providing clear, consistent, compatible and accessible information
ii. Accountability – so that decision-makers and budget holders can be held to account
iii. Simplicity – so that it is easy to understand what is going on
iv. Coherence – so that activities are clear logical[5]

Effective recording and management of expenditure is in line with this approach and will help LAs to ensure that data on cost-effectiveness of their system is as accurate as possible.

The cost calculator uses a mixture of already-inputted LA level data from the NDTMS) and user-inputted spend data. This estimates the daily spend (unit costs) on drugs and alcohol separately, including specific structured and non-structured high-level interventions and settings.

The calculator is automatically prefilled with inflated 2014-15 values from the 2013-14 Cost Calculator if your LA submitted this. If not, or if you wish to adjust any values, please complete the below steps.

[5] Taken from HM Treasury (2011). *Managing Taxpayers' Money Wisely: Commitment to action,* http://www.hm-treasury.gov.uk/d/managing_taxpayers_money_wisely.pdf

2a. Cost Calc - High Level

1. In cell C7, input your integrated substance misuse budget spend in 2014-15. This should include, as much as possible, your LA's entire spend on all drug and alcohol interventions (structured and non-structured) for adults.

2. Any spend on the commissioning system and LA overheads should not be included in the figure inputted into cell C7.

3. This will calculate your drug and alcohol structured treatment spend in cells C32 and E32.

   The terms 'alcohol' and 'drug' used throughout the cost calculator refer to service users who, respectively, are only in treatment for alcohol use and those clients who are in treatment for any drug use, even if alcohol treatment is a part of their treatment pathway.

4. Input either your non-structured spend (e.g. needle exchange services and alcohol health workers) or the proportion of global spend you invested in non-structured interventions into cells C17 and E17. Use the dropdown menus to select the right format (% or £s).

5. Automatically calculated drug and alcohol structured spend figures can be overwritten in cells C32 and E32. Only overwrite these if you know your actual spend. If actual spend is inputted, the integrated spend will be automatically calculated to sum the four boxes of structured and non-structured, alcohol and drugs expenditure.

Any cost estimates based on the above will be fairly crude. Users are encouraged to complete as much as possible of sections 2b (and 2c) to improve estimates.

2b. Cost Calc – Structured Treatment (Tx)

1. In rows 22-23, the Tool estimated your spend on the different structured treatment settings/interventions and the resulting unit costs in your LA using the treatment data from NDTMS in rows 17-20 and the inputted spend data from section 2a.

2. If known, the estimated spend can be entered for any of the structured treatment interventions/settings in row 28. This should include all service provision costs – direct costs, indirect costs (eg heating and lighting, time and travel costs) and overheads (eg HR and finance).

3. If you know the cost per day of an intervention, you can also insert this directly into any of the cells in row 29, and bypass any calculations.

4. Rows 31 and 32 are the most important in the cost calculator, as they determine the unit costs used in the Costs tab and CEA. In these rows, your LA's best available spend and unit costs are chosen from either rows 22-23 or rows 28-29. If known spends and/or unit costs have not been entered in rows 28-29, estimated spends and unit costs are taken from rows 22-23.

5. Inputted total spend or costs per day substantially higher (more than 1.5x) or lower (less than half) than the inflated national average are automatically highlighted red as a sense check.

2c. Cost Calc – Non-structured

Non-structured treatment data is not captured on NDTMS. As a result users wishing to calculate their spend and unit cost of non-structured interventions should input the number of service user contacts they have recorded locally during 2014-15 in row 16.

If you can input the number of service user contacts into the model, the national unit cost averages (cost per service user contact) adjusted for market forces are used to estimate the total spend on each non-structured intervention.

Like the previous tab, users can also input any known total spend or unit costs on non-structured interventions/settings which will overwrite the estimated spend calculated by the tool in rows 19-21.

Note: the Commissioning Tool only presents the cost-effectiveness of structured treatment at this time.

Section 3 – Annexes

Annex 1 - Published Unit Costs

This sheet includes the published national unit costs which are found as the third unit cost option on the *Cost Summary* sheet, and have been inflated from last year for 2014-15. Unit costs are inflated using the GDP deflator found in sheet *Annex 3 - MFF and GDP Deflator*.

Annex 2 - Definitions

This sheet provides both quick and detailed definitions of the information required, and the different intervention pathways. The definitions can be quickly accessed by clicking on buttons and question marks in some of the main sheets.

Annex 3 - MFF & GDP Deflator

This sheet lists the market forces factor factors that are used to adjust the published unit costs for cost differences around the country. No user input is required and this sheet is to make this information visible to the user for the purposes of transparency.

Appendix A – Detailed Calculations

1b. CEA - Drugs Tx and **1c. CEA - Alcohol Tx** sheets:

Average days in treatment:
Total pathway days (*from NDTMS*) ÷ number of clients = average days in treatment

Total spend in 2014-15:
This estimates the spend for each pathway, either single or combination:

Unit cost (user selected in Cost Summary) × Pharmacological days (from NDTMS) = Drug pharmacological spend

If the intervention pathway includes multiple intervention types, such as pharmacological and psychosocial, the total spend is the sum of spends on both interventions:

Total spend in 2014-15 = Pharmacological drug spend + Psychosocial drug spend

Spend per client in treatment
Total spend ÷ number of clients on pathway

Spend per successful client
Total spend ÷ number of successful clients on pathway

Pharmacological / Psychosocial / Recovery Support
The first column of each category is the sum of all clients in each sub-intervention, including clients who attended multiple sub-interventions. The columns for sub-interventions represent a percentage of the number of clients who attended that sub-intervention, for example:

Maintenance
=
Number of pharmacological maintenance clients (from NDTMS)
÷
Number of clients

2a. Cost Calc – High Level sheet:

Integrated Budget Expenditure (C7):
If values are entered for structured and non-structured drug and alcohol spends, then C7 is automatically calculated as the total of the five spends:

$$C7 = C19 + E19 + C32 + E32$$

Non-structured drug and alcohol spends (C19 and E19):
Both these cells cannot be entered into, but instead derive values from user entered values in C17 and E17, whether a spend or percentage amount:

If '£' is selected in the above drop down boxes: $C17 = C17$ *or* $E17 = E17.$

If '%' is selected: $C17 = C17 \times C7$ *or* $E17 = E17 \times C7$

Structured drug and alcohol spends (C32 and E32):
These values are automatically calculated based on the integrated spend in C7 after it has been entered. This is estimated using your inputted spend and NDTMS data. The calculation behind the results is shown in cells D32 and F32 (using drugs as an example):

Total number of days in drug treatment (C30)
÷
Total number of days in drug & alcohol treatment (C30 + E30)
×
Integrated budget expenditure (C7)
−
Total spend on non-structured treatment for drugs (C17) and alcohol (E17)

2b. Cost Calc – Structured Tx sheet:

Estimated spend (rows 22 and 23)
This section estimates the spend in your LA on individual treatment intervention/settings using the global spend disaggregation or known spend inputted by the user in *Sheet 2a*.

Using pharmacological drug treatment spend as an example, the estimated spend is calculated as follows*:*

Number of Pharmacological clients (E17)
÷
Total number of drug clients (I17)
=
Estimated proportion of the drugs expenditure spent on pharmacological treatment
×
The estimated or known total spend on drugs from Sheet 2a. (C32)
=
The estimated spend on pharmacological treatment

To get the unit costs for each structured treatment intervention/setting, the model divides the total spend (*row 22* for estimated or *row 28* for user inputted) by the number of days in each intervention/setting taken from NDTMS.

Both the total spend and unit costs for each intervention/setting can be overwritten in rows 28 and 29 if the user knows the true values of any of them.

2c. Cost Calc – Non-structured sheet:

This is very similar to the structured breakdown sheet and the equations are the same, albeit based on service user contacts rather than total treatment days. This sheet is provided for information only, as the Tool only presents the cost-effectiveness of structured treatment at this time