Date	December 2025
Report Title	**Background paper: Re-procurement of the Stockton drug and alcohol treatment and recovery service**
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Report Status	Information to inform decision making

1. Purpose

This background paper provides an overview of the re-procurement of the Stockton Drug and Alcohol Treatment and Recovery Service. It sets out:

- A summary of the current drug and alcohol treatment and recovery model.
- An overview of the existing Stockton service, including the service model, funding arrangements, and key outputs and outcomes.
- The steps undertaken to prepare for re-procurement.
- The recommended procurement route and proposed provider for the new contract.
- The options considered in determining the financial envelope for the new service.

2. Background

The Stockton's drug and alcohol treatment and recovery service, currently delivered by Change, Grow, Live (CGL) represents one component of a wider integrated system.

Overview of the drug and alcohol treatment and recovery model

This is a whole-system approach to drug and alcohol support, covering prevention, early intervention, structured treatment and long-term recovery. The system operates in partnership with social care, housing, health providers, criminal justice and voluntary sector to ensure coordinated care. It is also developed in-line with evidence base and examples of good practice, through close links to national and regional work and forums.

Key functions include:

- Accessible referral pathways, assessment and individualised care planning.
- Core harm-reduction services (needle exchange, naloxone, blood-borne virus testing).
- Psychosocial interventions and clinical treatment options, including opioid substitute therapy, detoxification and access to residential rehabilitation.
- Recovery support focused on housing, employment, peer support and community reintegration.
- Strong safeguarding, clinical governance and performance management arrangements.

Services are typically delivered across four tiers: universal prevention, targeted early intervention for those at risk, structured treatment and rehabilitation to support sustained recovery. The overall aim is to reduce harm, improve health and wellbeing and enable long-term recovery.

Funding model

- **Core Funding (Public Health Grant):** Local drug and alcohol treatment services are primarily funded through the Public Health Grant, in line with the Grant conditions. Stockton's core allocation is **£3.39million**, which funds the following elements:

    1. **Stockton drug and alcohol treatment and recovery service** (CGL, with Recovery Connections subcontracted).
    2. Naloxone provision and training (CGL).
    3. Needle exchange services (pharmacies).
    4. Supervised consumption of opioid substitution medication (pharmacies).
    5. Prescribing and dispensing (pharmacies).
    6. Specialist Family & Carers Service (Bridges).
    7. Local Drug Information System (multi-agency).
    8. Preventing Drug-Related Deaths function (multi-agency).

- **Additional Grant Funding:** Since 2021, Stockton has received annual supplementary funding through the national 10-year drug strategy *From Harm to Hope*. This funding is contingent on maintaining the core £3.39million Public Health investment and must be used to enhance rather than replace core spending. Deployment of the grant is subject to national conditions and reporting requirements.

3. Overview of the Stockon drug and alcohol treatment and recovery service

CGL was awarded the contract in 2020 on a 3+1+1 basis (to 31 March 2025) at an annual value of **£2.267 million** (£11.335 million over five years). The contract has been extended to 31 March 2026 to ensure alignment with learning from the national drug strategy and the Council's Complex Lives transformation project. CGL is the largest national provider of drug and alcohol services and operates in over 50 local authority areas.

This section provides an overview of the **current** Stockton service, covering:

- Service model and care pathway
- Service activity, performance, and outcomes
- Staffing model and costings
- Challenges and future demand considerations

3.1 Service model and care pathway

- **Entry into service and assessment**

The service ensures accessible, timely routes into treatment, including 24/7 online referrals, telephone triage, and daily open-access sessions at the Recovery Hub and satellite sites. A multidisciplinary duty team (clinical staff, coordinators, and recovery ambassadors) supports engagement and immediate needs. Triage matches each person to an appropriate Recovery Coordinator, reducing duplication and promoting sustained engagement.

- **Comprehensive assessment, risk management and harm reduction**

Holistic assessment covers substance use, physical and mental health, safeguarding, housing, and social support. Risk management is embedded throughout, supported by personalised care planning.

Immediate harm reduction is provided from first contact, including BBV testing, naloxone supply, drug-testing strips, and opportunistic advice via Making Every Contact Count. Same-day prescribing is available, with priority for high-risk groups such as prison leavers or those with complex needs.

- **Recovery coordination and structured treatment**

Each client has a named Recovery Coordinator who provides continuity, builds therapeutic rapport, and co-produces dynamic recovery plans. Plans integrate psychosocial, clinical and recovery-oriented interventions and are reviewed every 12 weeks. Delivery is supported by CGL's case management system and overseen by the Designated Safeguarding Lead.

- **Clinical interventions and nursing provision**

Clinical delivery is led by a Speciality Doctor with Consultant Psychiatrist input. Medical leadership oversees prescribing, MDTs, clinical supervision and mortality reviews, and works with primary care to improve management of dependence-forming medicines. The nursing team provides health assessments, community detox planning, OST titration, BBV screening and vaccination, naloxone distribution, wound care, ECG monitoring, smoking cessation, and specialist clinics (e.g., FibroScan, sexual health).

- **Psychosocial interventions (PSI)**

Evidence-based one-to-one and group interventions are delivered in line with NICE guidance. Staff are trained in motivational interviewing and trauma-informed care. Volunteers are trained to co-facilitate groups, strengthening capacity and lived-experience involvement.

- **Recovery support**

Recovery Connections (sub-contracted) delivers lived experience support from first contact through aftercare, offering coaching, peer mentoring, mutual aid groups, sober activities, volunteering and ambassador opportunities.

- **Children and Young People (CYP) pathway**

A dedicated CYP team delivers targeted resilience programmes and specialist treatment. Integrated assessments ensure CYP only tell their story once, with family support and harm reduction embedded. Prescribing and detox pathways follow NICE guidance and CGL policies.

- **Prevention, early intervention and health Inclusion**

The model places strong emphasis on prevention, early intervention, and tackling health inequalities. Targeted campaigns across digital and community channels, raising awareness of harm reduction, screening, and vaccination. Materials are co-produced with schools, pharmacies and VCSE partners, and pop-up events in high-footfall areas increase visibility and early help-seeking.

A Prevention and Early Intervention Coordinator provides a phased offer for non-dependent users, from brief advice for low-risk individuals to extended brief interventions (EBIs) for those at increasing risk. EBIs are evidence-based, substance-specific and designed to prevent escalation. Where structured support is required, individuals transition seamlessly into the Entry into Service pathway.

3.2 Service activity and performance

The Stockton CGL service continues to perform strongly, demonstrating a resilient and responsive service model when compared with similarly sized and funded services nationally. This strength and adaptability were also evident during the Covid-19 pandemic.

Treatment activity

- **High and increasing caseloads:** Data from September 2025, **1,733** adults and **46** children and young people have accessed support (rolling 12-month figures). Since the start of the contract in 2020/21, treatment numbers have grown by 14% for adults and 59% for children, indicating increased engagement and improved reach across the borough.

- **Demographics:** Among adults in treatment, 66% are male, with adults aged 30–49 making up 65% of the cohort.

- **New presentations:** The service is seeing sustained growth in demand, with 50% more new adult presentations and 44% more new CYP presentations on average compared with 2020/21.

- **Treatment progress:** On average, 46% of adults in treatment make significant progress, either successfully completing treatment or meaningfully reducing or stopping their substance use. This is in line with national benchmarks. Around one-third leave treatment in an unplanned way for a range of personal, social, or clinical reasons, which is also consistent with national benchmarks.

- **Presenting needs:** Adults typically present with a mix of dependencies, opiate or non-opiate use (with or without crack), crack-only use, and or alcohol dependence.

Individual treatment outcomes

Outcomes for service users are positive and compare favorably with national benchmarks.

- **High satisfaction:** 99.5% of service users report a positive assessment experience.
- **Improved wellbeing:** Average scores for overall satisfaction, physical health, psychological health and quality of life all increase between first review and treatment exit.
- **Increased abstinence:** Across all substance groups, abstinence rates improve at mid-treatment review and increase further at planned treatment exit.

Population-level outcomes
Reducing unmet treatment need is a key indicator of system performance. Stockton continues to perform strongly in this area, outperforming both the national and Northeast averages (see Table 1). Of note, unmet need among people using both opiates and crack is **10.5%**, significantly lower than the national average of **45%**. This reflects the service's strong community reach, robust partnerships, and the ability of CGL to effectively engage and retain people in treatment.

Table 1. Unmet Treatment need by substance, Stockton-on Tees compared to England and North-East average, June 2025 (Source: NDTMS)

Unmet Treatment Need Per Substance – June 2025 (NDTMS)			
Substance	**Stockton-on-Tees**	**North-East**	**England**
Opiates Only	48.2%	55.9%	61.9%
Crack Only	53.6%	56.3%	73.6%
Both opiates and crack	10.5%	26.9%	44.8%
Alcohol	75.7%	72.9%	75.7%

The service has also achieved regional and national recognition, including:

- Identified by OHID as a best-practice site for engaging opiate users (one of only 30 areas nationally).
- Regional lead for continuity of care for prison leavers, improving outcomes from 51% (Jun 2023) to 72% (Jun 2025) (England 54%; NE 61%).
- Lowest waiting times nationally across all CGL services—0.15 days in 2024/25, down from 9.73 days in 2023/24.
- First locality in the Northeast to achieve micro-elimination of Hepatitis C (2024).

*It is important to note that the core service is funded through the main contract, while several enhancements have been made possible using the additional grant funding. These enhancements have supported increases in the number of people in treatment, reduced individual practitioner caseloads (towards a target of fewer than 40), improved continuity of care for people leaving prison, and expanded access to rehabilitation placements. When reviewing service outcomes, it is therefore important to recognise that this additional grant funding has played a role in supporting the strong performance achieved.

3.3 Staffing model and costings for the current service

CGL was awarded the contract in 2020 on a 3+1+1 basis (ending 31 March 2025) at an annual value of **£2.267 million**, totaling £11.335 million over five years. The contract has been extended to 31 March 2026.

- **Staffing Model**

The service is delivered by a **multi-disciplinary workforce**, including nurses, a psychiatrist, non-medical prescribers, recovery coordinators, specialist frontline roles, management, and administrative support. **Notably, over 30% of the workforce brings direct lived experience**, which strengthens engagement, recovery support and service credibility.

Staffing represents over **70% of contract expenditure**, reflecting the labor-intensive nature of treatment and recovery support. CGL also subcontracts recovery support functions to **Recovery Connections**, enhancing peer support, community integration, and volunteering capacity (6% of contract expenditure).

- **Non-Staffing Costs**

Expenditure includes:

- Clinical delivery costs (detoxification, testing, needle exchange)
- Property rental, utilities and estates costs
- IT systems and infrastructure
- Office equipment and supplies

Benchmarking contract value against comparable services

CGL is the largest national provider of drug and alcohol services, operating across more than 50 local authority areas. When benchmarked against similar CGL services nationally, Stockton's annual contract value (£2.267 m) is slightly below the average of £2.407 million. On a per-client basis, Stockton's average cost per service user £2,287 is lower than the national average for comparable services of £2,496. It is important to note that these comparisons are limited to CGL-run services and do not include locally commissioned services from other providers.

3.4 Contextual considerations for re-procurement of the new contract

The re-procurement of the drug and alcohol treatment service takes place against a backdrop of evolving pressures across the sector. Since the launch of the national drug strategy *From Harm to Hope*, services have been expected to deliver more ambitious improvements while managing rising demand, increasing complexity, and changing drug trends.

Future demand and prevalence

Forecasting future demand is challenging. National prevalence estimates were last updated in 2020 and do not capture non-opiate use, despite local intelligence and stakeholder feedback indicating these substances are becoming increasingly common. While future treatment need is difficult to quantify, it is reasonable to expect growing complexity within the treatment population.

Key trends shaping future service requirements

• Ageing opiate cohort

A substantial group of long-term heroin/opiate users is ageing, presenting with multiple physical health conditions, higher levels of frailty, greater safeguarding needs, and increased risk of early mortality and drug-related deaths. Some are entering care homes earlier than the general population, requiring specialist support.

• Shifting drug trends

Local and national data show a shift away from heroin towards crack cocaine, non-opiate substances, tablets, ketamine and illicit vapes. This diversification increases treatment complexity and requires different clinical and psychosocial responses.

• Synthetic substances

The emergence of synthetic opioids (e.g. nitazenes) and synthetic cannabinoids (e.g. "Spice") continues to pose significant risk due to potency, unpredictability, and links to overdoses.

• Multiple disadvantage and wider determinants

Housing instability, homelessness, mental and physical ill-health, domestic abuse, unemployment and poverty all continue to feature prominently locally. These factors increase vulnerability, impact treatment engagement, and require service models that work across organisational boundaries to address wider needs.

• Changing prescribing approaches

Long-acting injectable buprenorphine (Buvidal) is clinically effective and positively regarded by both staff and service users. However, cost remains a significant constraint on wider rollout. Regional and national work by OHID may increase expectations around uptake.

• Tackling stigma and promoting visible recovery
Stigma remains a major barrier to treatment access and sustained recovery. National and regional initiatives, such as the development of Inclusive Recovery Cities (IRC), are strengthening expectations for more visible, community-led recovery systems.

• Limited out-of-hours support
Gaps in weekend and out-of-hours provision continue to pose risks, particularly during drug alerts and in preventing non-fatal and fatal overdoses. This results in increased presentations to urgent care and highlights the need for future models to consider improved resilience outside core hours.

Cost pressures
These challenges are compounded by wider system pressures, including the financial impact of COVID-19, cost-of-living and inflationary increases, and constrained local authority budgets. National providers such as CGL have had to review operating models across multiple areas in response to rising costs.

Despite these pressures, CGL has maintained strong performance and service continuity and monitoring and management of ongoing staffing, activity, and cost drivers.

4. Re-procurement processes to date and considerations

Since September 2024, public health and procurement have worked together to progress the project plan for re-procurement of substance misuse services. Table 2 sets out some of the key activities which have been undertaken to date.

Table 2. Re-procurement preparation and governance processes

Item	Date (2025)
Cabinet paper Annual Procurement Plan	13th March
Health Needs Assessment completed	May
Stakeholder consultation	June
Establishing a re-procurement steering group (across SBC Directorates)	18th June
CLG & Bridges Service Reviews reported	July
Procurement Consultation Form	11th August
Briefing Director (Majella McCarthy)	29th August
Briefing Cllr Beall	August

- **Rationale for the PSR Direct Award and choice of provider**

The Provider Selection Regime (PSR), which came into force on 1 January 2024, replaces traditional competitive tendering for health and care services with a more flexible and proportionate procurement framework. The PSR applies to all public bodies commissioning healthcare services in England, including local authorities and is designed to promote transparency, reduce unnecessary bureaucracy, and prioritise service quality and integration.

A key element of the PSR is **Direct Award Process C**, which enables commissioners to award a contract directly to an incumbent provider where the provider is performing well, and the service model and contract requirements will not change substantially.

As outlined above, Stockton's drug and alcohol treatment and recovery service delivered by CGL is performing strongly against national targets and local indicators and contributes positively to wider system priorities. Based on consistently strong contract performance, effective and embedded partnership working, and demonstrable positive outcomes for service users, it was proposed that a **Direct Award under the PSR** would be the most appropriate route for re-procurement.

A direct award offers the following benefits:

- **Service continuity:** Maintains stability and avoids disruption to a critical statutory service by retaining a proven, high-performing provider.
- **Market stability:** Limits disruption within the provider market and supports smooth transition arrangements.
- **Strengthened collaboration:** Enables continuity of strong multi-agency partnerships and supports integrated working across the health, care and community system.
- **Quality assurance:** Incentivizes providers to maintain high standards, as strong performance is a prerequisite for direct award.
- **Increased efficiency:** Allows commissioners to focus on service outcomes and quality improvement rather than lengthy, resource-intensive procurement processes.
- **Reduced administrative burden:** Minimises the time and cost for both the Council and providers associated with running a competitive tender.

5. Options appraisal for the financial envelope of the next 5-year contract

5.1 Two proposed financial options

The Council continues to operate within a challenging financial environment, and any proposed option must therefore be affordable and avoid creating unfunded commitments. In addition, continued access to the additional national drug strategy grant is contingent on maintaining the Council's baseline investment in drug and alcohol treatment and recovery services. Any reduction in the baseline contract value would place this additional funding at risk, which currently supports enhanced service capacity and improved outcomes. Within these parameters, two financial options have been considered.

Option 1 – Maintain Current Baseline Contract Value (Minimum Viable Service)

Opton 1 proposes maintaining the current contract value of £2.267m per year over the new five-year term, with no uplift or additional investment**.** This represents a total contract value of **£11.335 million.**

Under this option, the service would operate as a minimum viable offer. This represents the essential level of provision required to:

- Meet statutory and contractual duties (open access, harm reduction, treatment pathways).
- Maintain safety and safeguarding for service users and the public.
- Protect core treatment capacity (e.g., prescribing, structured treatment, needle and syringe provision, care coordination).
- Prioritise resources for high-risk individuals and the most critical functions.
- Remain scalable if future funding becomes available.

Implications

Impact on Service Offer and Delivery
A minimum viable service is expected to **maintain the current caseload** of approximately 1,700 but cannot expand capacity. Maintaining this caseload would require several trade-offs, including:

- Reduced recovery coordinator capacity, resulting in higher caseloads per worker.
- Reduced prescribing and administrative support.
- Less dedicated capacity for harm reduction, dual diagnosis, and psychosocial interventions.
- Reduced frequency of clinical reviews (although remaining within NICE guidelines).

These changes are likely to:

- Impact service quality and performance against some quality metrics.
- Require more stringent triage, meaning some individuals would receive a reduced offer.
- Limit the capacity to address unmet need, respond to new drug trends, manage increases in demand, or meet new national requirements.

This option delivers a safe, statutory compliant and financially achievable service, maintains current caseload capacity, and avoids the need for additional funding commitments.

Option 2 – Maintain current baseline contract value with a year-on-year uplift mechanism

Option 2 retains the existing baseline contract value of £2.267m per annum but applies a year-on-year uplift to reflect inflationary pressures and maintain more than the minimum operational viability over the 5-year contract term.

Proposed uplift mechanism: The proposed rates are 3% for staffing costs and 2% for non-staffing costs, based on the current 70:30 (staffing/non-staffing) cost ratio. These rates reflect actual provider cost pressures while remaining below national indices such as RPI, CPI, and wage growth.

Over five years, this option would result in a total contract value of **£11.964 million**, an **increase of £628,840** compared to Option 1.

Implications

Impact on Service Offer and Delivery
Under Option 2, the service would operate at a level closer to the current model, maintaining core capacity and quality.

Key impacts include:

- Capacity to maintain and gradually increase caseload over the five-year contract.
- Preservation of service quality, safeguarding key clinical and psychosocial functions.
- Improved ability to respond to emerging drug trends and fluctuations in demand.
- Continuation of recognised good practice, Stockton's service has received both regional and national commendation.
- Sustain best practice in priority areas, supporting continued strong performance.
- Strengthens the service's contribution to the Council's Complex Lives transformation project.

Option 2 offers a more resilient service model. It maintains the strengths of the current service, protects quality and outcomes, reduces the risk of workforce instability. This is not the recommended option due to budget challenges and pressures given that the additionality is not via guaranteed funding from the grant and leaves the Council in a position of underwriting this risk.

Table 3: Summary Comparison of Proposed Financial Option

Criteria	Option 1: Maintain Current Baseline (Minimum Viable Service)	Option 2: Maintain Baseline with Year-on-Year Uplift (Recommended)
Annual value	£2.267m (fixed for 5 years)	£2.267m baseline + annual uplift (3% staffing; 2% non-staffing)
Total contract value	**£11.335 million**	**£11.964 million**

Criteria	Option 1: Maintain Current Baseline (Minimum Viable Service)	Option 2: Maintain Baseline with Year-on-Year Uplift (Recommended)
Affordability	Low financial impact; affordable within the current PH budget, no additional investment	Requires an additional investment of **£628,840** over the contract length
Service model	Minimum viable service	Closer to the current model
Capacity to meet demand	maintain the current caseload of approximately 1,700 but limited capacity to expand	Capacity to maintain and gradually increase caseload over the five-year contract
Quality of interventions	Possible impact quality of service for some clients as higher caseloads per worker	Sustains current quality; protects best-practice delivery
Responsiveness to emerging trends	Limited ability to respond to emerging needs	Some flexibility to respond to emerging drug trends and increases in demand
Risk to additional national funding eligibility	Baseline maintained; eligibility preserved	Baseline maintained; eligibility preserved
Overall sustainability	Possibility of some level of deterioration over contract period, if further demand and funding streams are not aligned in the national grant payment.	More resilient and future-proofed model
Overall assessment	Delivers a safe, statutory compliant and financially achievable service, maintains current caseload capacity, and avoids the need for additional funding commitments, which currently cannot be guaranteed. However, it represents a risk-managed service model.	More sustainable, more likely to protect quality outcomes and service capacity. However, requires an additional investment of **£628,840** over the contract length

Appendix 1: CGL Client level outcomes

Change Grow Live

Assessment Experience

How did you find the assessment?	2021-22	2022-23	2023-24	2024-25	2025-26	Total/Ave
Positive experience	527	517	860	799	497	3200
Negative experience	4	1	3	8	0	16
% positive experience	99.2%	99.8%	99.7%	99.0%	100.0%	99.5%

Source : Entry into Service/Personalised Assessment

During the Assessment process, we do ask how our service users found the experience - as demonstrated, 99.5% said positive.

Health & Wellbeing, Involvement & Satisfaction

	TOPS Outcomes (First Review)					
Average Score (0-20)	2021-22	2022-23	2023-24	2024-25	2025-26	Total/Ave
Involvement	16.2	16.7	17.0	17.8	18.4	17.1
Satisfaction	16.7	17.0	17.2	18.2	18.5	12.7
Physical Health	12.9	12.8	12.4	12.5	12.7	11.9
Psychological Health	12.4	12.2	11.6	11.7	11.7	12.5
Quality of Life	12.7	12.7	12.0	12.3	12.7	17.4

	TOPS Outcomes (Treatment Exit Review)					
Average Score (0-20)	2021-22	2022-23	2023-24	2024-25	2025-26	Total/Ave
Involvement	17.8	17.9	18.3	18.6	18.6	18.2
Satisfaction	17.9	17.9	18.5	18.6	18.8	14.6
Physical Health	15.0	14.4	14.7	14.5	14.2	14.5
Psychological Health	14.8	14.2	14.6	14.2	14.6	15.1
Quality of Life	15.3	14.9	15.3	14.9	15.2	18.3

	TOPS Outcomes (Progress)					
Average Score (0-20)	2021-22	2022-23	2023-24	2024-25	2025-26	Total/Ave
Involvement	1.6	1.1	1.3	0.8	0.3	1.1
Satisfaction	1.3	0.9	1.3	0.5	0.3	0.9
Physical Health	2.1	1.6	2.4	2.0	1.4	1.9
Psychological Health	2.4	2.0	3.0	2.5	2.9	2.5
Quality of Life	2.6	2.2	3.3	2.5	2.5	2.6

Source : NDTMS/TOPS

As per NDTMS requirements, we do collate clients ratings of their Physical Health, Psychological Health and Quality of Life at treatment start, review and exit (0-20 scale).

Internally we also ask the folliwing;
How involved do you feel in the decisions made about the support you receive?
How satisfied are you with the support you receive?

As the average scores demonstrates from first and exit review, all measures show an increase.

Quality of Life has increased the most by 2.6, followed by Psychological Health which has increased by 2.5.

Abstinence

Opiate Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	57%	50%	55%	68%	68%
Abstinence (Planned Exit)	100%	96%	95%	96%	93%

Crack Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	36%	31%	23%	20%	25%
Abstinence (Planned Exit)	100%	86%	93%	86%	86%

Cocaine Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	57%	44%	52%	49%	47%
Abstinence (Planned Exit)	87%	62%	76%	84%	85%

Cannabis Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	26%	39%	26%	18%	20%
Abstinence (Planned Exit)	35%	56%	37%	41%	40%

Alcohol Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	21%	26%	21%	27%	27%
Abstinence (Planned Exit)	43%	42%	46%	46%	49%

Tobacco Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	11%	19%	17%	13%	16%
Abstinence (Planned Exit)	16%	25%	19%	24%	26%

Injecting Clients	2021-22	2022-23	2023-24	2024-25	2025-26
Abstinence (Review)	65%	56%	58%	79%	16%
Abstinence (Planned Exit)	100%	100%	100%	100%	100%

Source : NDTMS/TOPS

The following demostrates abstinence, comparing review and planned exit;
Opiate
Crack
Cocaine
Cannabis
Alcohol
Tobacco
Injecting

As demonstrated, all measures show a positive abistence rate at review and even greater absitence at exit (as expected).