Published as: Resnick, S. & Griffiths, M.D. (2012). Delivering service quality in alcohol treatment: A qualitative comparison of public and private treatment centres. *International Journal of Mental Health and Addiction*, 10, 185-196.

Delivering service quality in alcohol treatment: A qualitative comparison of public and private treatment centres by service users and service providers

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Abstract

In the UK, quality of care has now been placed at the centre of the National Health Service (NHS) modernisation programme. To date, there has been little research on the service quality delivery of alcohol treatment services from the perspective of both the service user and service provider. Therefore, this qualitative study explored the perceptions of healthcare service delivery among problem drinkers and alcohol treatment service providers in both an NHS service and a private clinic (n=70). The NHS sample comprised 17 patients and 13 members of the healthcare team. The private clinic sample comprised 25 patients and 15 members of staff. Thematic analysis revealed four key themes: (1) how service quality delivery is defined; (2) funding of services; (3) choice in alcohol treatment services; and (4) processes and measurements of service delivery. The main factors influencing the service expectations of problem drinkers were their personal need for treatment and past experience of services. An additional factor that emerged from the study was the range and level of services that problem drinker can access creating a 'revolving door' practice. Implications arising from this study are also discussed.

Keywords: Alcohol treatment; Patient-provider relationships; Problem drinking; Revolving door; Service quality.

Introduction

Healthcare in the UK is primarily delivered through the National Health Service (NHS). This was established in 1948 on the premise of free and universal state-provisioned medical care (Klein, 2006). Private sector healthcare accounts for around 17% of the total UK health expenditure to which access is determined not by need but by the ability to pay (Laing, 2001). A 1997 UK Government White Paper (*The New NHS, Modern, Dependable*) pledged to improve the quality of service delivered by the NHS and to shift the focus onto quality of care so that excellence is guaranteed to all patients (Ham, 1999).

Quality of care was placed at the centre of the NHS modernisation programme and presented as a series of measures designed to raise quality and decrease variations in service (Leatherman & Sutherland, 2003). A series of Government commitments and performance targets were set out with emphasis on capacity indicators such as waiting times as a benchmark of meeting service quality expectations (Department of Health, 2006). The UK Government also declared that NHS patients should have more choice about care and treatment (Baggott, 2004). Patient choice was seen as a way of meeting some key performance targets by allowing people to be treated by private providers and it was perceived that choice would be popular amongst patients. However, assessing choice in healthcare is more complex than making choices about consumer services and having choice may not improve health outcomes (Appleby & Dixon, 2004).

The emphasis on quality in the NHS recognised the importance of meeting patient expectations and defining outcomes, which for many medical disorders are important criteria by which to judge service performance. However, the application of these criteria to alcohol treatment services and problem drinkers is more debatable and the aim of this study is to explore service quality expectations and perceptions within alcohol treatment from the perspective of both the service user and the service provider and to explore how expectations and perceptions compare between a public and private treatment provider.

Alcohol treatment in the UK

The consumption of alcohol in the UK has risen by over 50% since 1970. In England, 26% of the population (8.2 million people) have an alcohol use disorder with 1.1 million of these classed as alcohol dependent (Department of Health, 2005a). The estimated cost

to the NHS in the treatment and care of alcohol related medical conditions is approximately £1.7 billion per annum (Prime Minister's Strategy Unit, 2004). Problem drinking is defined as occurring when there is clear evidence that alcohol is responsible for physical and/or psychological harm, which can result in not only physical and mental illness to the individual but harm to the physical, mental and social well being of others (Royal College of Physicians, 2001). As a condition, problem drinking does not follow a conventional illness and recovery process (Edwards, Marshall & Cook, 2003) and the means by which specialist treatment is accessed can vary from one general practitioner (GP) to another (Department of Health, 2005b). Despite additional investment into the NHS, the current service provision for treating problem drinking is said to be 'patchy' with no established or consistently applied performance indicators (Prime Minister's Strategy Unit, 2004).

In the UK, the organisation of alcohol treatment is very fragmented both in numbers of services and in treatment approaches. The NHS offers controlled drinking programmes but many other private and voluntary services are based around the 12-Step abstinence approach. NHS specialist alcohol treatment units are organised to deal with complex cases of problem drinking. All of these NHS services are currently funded from Primary Care Trusts (PCT) whose purpose is to implement national health priorities, where they are accountable to the Department of Health but also have responsibility to plan and fund health services within the local community (Klein, 2006). Voluntary alcohol treatment agencies can provide services for a range of problem drinkers and receive funds from various sources such as local authorities, charities, and the PCT (Touquet & Paton, 2006) and private alcohol treatment services cater for privately funded programmes but may also receive public funding from the PCT for a number of NHS referred patients. These differing and multiple service provisions have resulted in a diverse and fragmented service environment that has invited competition for funding. In addition, problem drinkers may not possess the physical and/or mental capacity to make appropriate choices (Edwards, *et al,* 2003). Numerous choices of treatment services allow movement from one service to another and back again, creating a 'revolving door' practice (Resnick & Griffiths, 2009). The 'revolving door' also shapes service expectations as many problem drinkers have experienced a number of treatment providers and this influences expectations of subsequent service provision.

Service quality in healthcare

In professional services such as healthcare, it appears that patients have unclear expectations about what they expect from the service provider and are often unsure whether the service has met their expectations (Ojasalo, 2001). Furthermore, Stewart, Hope and Muhlemann (2000) suggest that accessing a professional service is perceived as involving a higher level of risk than purchasing consumer services. This is because the client does not often have the technical skills to evaluate the quality of the professional service delivery. Research in professional services has indicated that the service provider-client relationship has the most influence on the perception of service quality delivery (Stewart, *et al,* 2000). This is supported by the view that quality lies in the individual practice and attitudes, skills and knowledge of the healthcare providers (Leatherman & Sutherland, 1998).

A significant strand of the NHS modernisation was the introduction of quality models and techniques to monitor service delivery, measure performance and bring about organisational change (Leatherman & Sutherland, 2003). These models can be useful in providing an overview of factors that affect the quality of the organisation, facilitate understanding, and explain how quality shortfalls occur. They can also provide a framework for quality programmes, which can channel the efforts of an organisation in the right direction.

Service Quality Model

Concepts of expectations and perceptions formed the basis of the service quality model of Parasuraman, Zeithaml and Berry (1985) who defined service quality as the provision of a service in meeting or exceeding customer expectations. The Parasuraman, *et al,* (1985) model suggests that four factors and five service quality dimensions shape customer expectations of a service (see Figure 1)

INSERT FIGURE 1 ABOUT HERE

Using this model, an evaluation tool, SERVQUAL was developed. This tool measures customers' expectations and perceptions of the five service quality dimensions (Zeithaml, Parasuraman & Berry*,* 1990). The literature supporting SERVQUAL is significant in terms of studies using this service quality measurement approach in healthcare services (e.g., Youssef, 1996; Conway & Willcocks, 1997: Curry & Sinclair, 2002: Silvestro, 2005).

The service quality dimensions of SERVQUAL have been criticised in that they are not applicable to all services (Babakus & Boller, 1992) while other studies suggest that different types of dimensions are applicable to different services (Carmen, 1990). However, in the context of service quality in the NHS, the 'care' dimensions of medical treatment relate well to the SERVQUAL dimensions (Gabbott & Hogg, 1999). These dimensions have been used in the following study to qualitatively explore the perceptions of healthcare service delivery from the perspective of a sample of problem drinkers and their healthcare providers in both the NHS and in a privately funded alcohol treatment service.

Method

Design: As quality in healthcare can be shaped by the individual practice and attitudes, skills and knowledge of the healthcare providers (Leatherman & Sutherland, 1998) it was intrinsic to the research that both perspectives of how service quality is delivered was explored. Qualitative, in-depth, semi-structured interviews were employed (comprising questions detailed in Appendix 1) amongst both patients and the healthcare providers. Patients and healthcare staff were recruited through a notice in the clinics requesting participation. Interviews of on average 45-minute duration were tape recorded and the data transcribed and data coded around the topics detailed in Appendix 1. Further thematic analysis was then undertaken, which revealed four key themes around service quality delivery. The study was undertaken amongst patients and staff in an NHS and a privately funded alcohol treatment clinic in a UK city in the Midlands, UK. The NHS clinic offers a treatment programme based around day care and a controlled drinking approach. The private clinic programme is residential and based on an abstinence approach to problem drinking. Of the sixteen patient beds, seven are funded by the PCT for NHS referred patients with the remaining nine beds funded privately.

Participants: Two groups of participants at both treatment clinics were interviewed. The NHS clinic interviews were undertaken amongst 17 patients and 13 members of the healthcare team. The patient sample comprised 76% males and 24% female with an average age of 45 years. Three quarters of the sample had left school aged 16 years or younger and 88% of the sample was currently unemployed. Among the patient sample, 15 of the 17 participants had accessed other alcohol treatment services at some stage, and

10 of the sample had re-accessed the NHS service on other occasions. Of the 13 members of the NHS healthcare team interviewed, 61% were male and 39% female. The average length of employment in the service was 12 years.

The private clinic sample comprised 25 patients and 15 members of staff. Of the patient sample, 64% were males and 36% females with the average age of 43 years. Two-fifths of the patients had been educated to degree level or above, with a further 16% having attended school or college. Over half of the sample (52%) comprised private patients with the remaining patients funded by the NHS (48%). The average length of stay was 17 days. Over 60% of the group had accessed other alcohol treatment facilities and of these, a quarter (26%) had accessed the same private treatment clinic on a previous occasion. A quarter of the participants were professionals as defined by their job, 35% were in active employment and 8% were from the armed forces. Of the staff sample, 15 members of the private treatment clinic were interviewed and this sample was made up of 40% males and 60% females with the average length of time employed in the clinic of just over two and a half years.

Results

Following transcription of all 70 interviews, thematic analysis revealed four key themes. These were: (1) How service quality delivery is defined; (2) Funding of services; (3) Choice in alcohol treatment services; and (4) Processes and measurements of service delivery.

How service quality delivery is defined

Results indicated that service quality meant different things to participants in the study. Patients and staff of the NHS clinic perceived service quality as the delivery of good clinical care and an empathetic relationship between the service provider and user. NHS patients defined service quality by their personal relationship with the healthcare team, the care they received, the attitude of the staff towards their problem drinking and the way in which they felt personally supported. For instance:

> *'It's people who know what to do…know what it's about and are interested in you as a person'*. (NHS patient, male, 57 years).

For another NHS patient (female, 41years) it was *'a high standard of care for patients and a respect and concern for them'*. One NHS patient had suffered a deprived childhood, started drinking at 13 years old, and been homeless for several years but commented on the support he received from the healthcare team:

> *'They really encourage you, it's not just to quit the alcohol, it's daily life and if things are troubling you they help'* (Male, 41 years).

Some patients had harboured low expectations about the service they might receive having experienced judgemental reactions to their drinking problem in the past. One patient revealed that he '*felt ashamed discussing my problems but staff here make you feel you are not alone.'* (NHS patient, male, 34 years).

The NHS healthcare team defined their notion of service quality around meeting patient needs, which was achieved through training, their healthcare professionalism in building the relationship with the patients and through**:**

> *'Listening to clients...finding out from them what they want from the service, being adaptable and flexible, bearing in mind the reasons why they are here'* (NHS Nurse).

Another team member suggested that '*it's the right blend of experienced staff that have the knowledge and skill to relate to the client group'* (NHS Nurse) and another believed it was about:

> *'Providing a professional service, foundered on evidence and best possible treatment to clients…warmth, flexibility, accepting, humanistic'* (NHS Clinic Manager).

The main attributes articulated by both patients and staff as key to their relationship was those of trust, helpfulness, understanding, and reliability.

Private clinic patients defined service quality in terms of achieving recovery from problem drinking and receiving a professional service. When asked to describe how service quality is delivered at the clinic, many patients talked about expertise, training, structure and the physical delivery of services and used the term 'professional' as a descriptor of these activities. One patient talked about how staff members were *'experts in what they are doing.'* (Male, 34 years) and another commented on the *'skills of the staff.*' (Male, 25 years). It was suggested that *'therapists were well trained'* (Male, 54 years) and that staff were *'very professional',* (Male, 52 years) and the *'medication as being well administered.*' (Male, 56 years). One patient (Female, 44 years) perceived that she was receiving a 'c*lear and structured programme'*. Professionalism was also perceived in the sense of the physical

attributes of the service such as the detoxification process and the group therapy sessions.

Asked how they deliver service quality, the staff of the private treatment clinic articulated this in terms of training and knowledge, and used the term 'professional' to describe themselves. One staff member (Nurse) defined service quality delivery as having *'qualified individuals that can deal with patient problems'* and professionalism for some staff was derived from *'training and guidelines'* (Therapist). Although the patients of the private treatment clinic appreciated the professionalism of the staff, it could be suggested that this approach, coupled with an emphasis on group rather than individual therapy, distances them from patients, prevents the development of one to one relationships and creates an 'empathy' gap, which was not apparent in the NHS healthcare team's relationship with their patients.

Funding of services

A report on alcohol treatment services by Alcohol Concern (2002) identified under-funding across services from all sectors, with 87% reporting funding as either static or declining and with an estimated increased funding of 30% needed to fully meet demand. Patients in the NHS clinic articulated a resource issue primarily in terms of lack of staff in the service. One patient believed:

> *'They could do with some more staff. They have not replaced the [occupational therapists'* (NHS patient, male, 59 years).

Another NHS patient (male, 46 years) described the service as *'short of money like all the NHS*' with another patient suggesting that the clinic needed:

> *'More money and that sometimes there is not enough staff, especially if new patients arrive.'* (Male, 49 years)

An insufficient staffing resource was also an issue for the NHS healthcare team. NHS alcohol services are often combined with drug treatment, and as part of a ten-year programme to combat drug misuse the Government has funded the expansion of drug treatment services (Department of Health, 1998). Over the same timescale, funding for NHS alcohol services has remained static and a member of the healthcare team suggested that:

> '*Alcohol plays second fiddle to drugs. Since HIV came to the forefront, money has been pumped into drug [treatment]...creating drug action teams and alcohol is not achieving the recognition the problem presents.'* (NHS Nurse).

This picture of drug treatment, as the leading edge of the combined services, was articulated as *'drugs have a trendy image but the image of someone with alcohol problems is more of a tramp'* (NHS Nurse). Several members of the healthcare team referred to alcohol treatment as the 'Cinderella' service, and a member of the team summed up other issues around funding as:

> *'Alcohol [treatment] has been forgotten about. Drug misuse, crime associations, media attention have all been on drugs, therefore that's where the money has been spent.'* (NHS Ward Manager).

Funding issues for patients in the private clinic were identified as the challenge of accessing treatment. There is a large gap between the provision of alcohol treatment and need or demand, with perceived difficulties in accessing specialist treatment because of waiting lists (Department of Health, 2005b). The PCT for the city where the study took place, fund seven NHS beds at the private treatment clinic but other PCTs do not have this facility either because the beds and/or the funding are not available. For two patients who lived outside the city, this was articulated as healthcare by 'postcode lottery'. One patient confirmed that he:

> *'Wrote to my MP…[that alcohol treatment] is [a] postcode lottery. I was told they are cutting beds [locally] and moving to care in the community'* (Private patient, male, 56 years).

Another patient (Male, 54 years) noted that he went back to his GP who said treatment was a 'postcode lottery' and that the locality had no funding for this type of treatment. Research suggests that alcohol treatment services are currently under-funded and failing to cope with current demand (Department of Health, 2005a) but there is a wide choice of services within alcohol treatment, up to 23 services within the city where the study took place, which creates competition for funding and a 'revolving door' practice.

Choice in alcohol treatment services

From the sample of 17 NHS patients, 15 had accessed other alcohol treatment providers at some stage. A member of the NHS staff commented that:

> *'People can buzz around between different services...they can sometimes bump into what suits them but at other times the number of services makes it more complex'* (NHS Consultant)

Another member of the NHS staff team believed that the choice of services:

> *'Makes it easy for the patients… there is always an alternative for them. A lot of the patients have been round the houses'* (NHS Nurse).

The general view amongst the NHS staff team was that there was a wide range of services that has led to competition for funding amongst the service providers. The provision of alcohol services within this particular city was described as

> '*Right there from short-term advice right through to intensive support around chaotic and problem drinking. The philosophies are quite polarised* (NHS Nurse).

The numbers of alcohol treatment services and their different approaches to treatment may not be helpful to problem drinkers as this enables them to move from one service to another and back again. A number of patients at the NHS treatment clinic were on their fifth treatment attempt having accessed other alcohol treatment services en route. As a member of the NHS nursing team observed '*we (NHS) have a revolving door policy in that that they can come back in.'* It is not only the number of services on offer but a different solution to problem drinking in terms of treatment ranging from an abstinence approach, controlled drinking, and the 12-Step approach. This choice is not always helpful as it legitimises patients moving from one service provider to another and back again, '*seeking the magic solution'* (NHS Clinic Manager).

Of the 15 private clinic patients who had accessed other treatment services, nine patients had experienced the NHS controlled drinking treatment programme, but many of these patients reported failure with controlled drinking:

> '*I went to the NHS clinic controlled drinking but ended up drinking more. [I] tried to cut down but found it impossible'* (Private clinic NHS funded patient, male, 37 years))

Another private patient had been assigned a key worker in the NHS but *'saw her only four times a month and needed more time'* (Private clinic NHS funded patient, female, 58 years). Members of staff of the private clinic were not convinced that choice in alcohol services was helpful:

> *'Choice options give a clear idea of what the service is going to provide. Choice within different levels is debatable and it is questionable whether you need ten services for counselling. When an individual decides to do something about their problem then treatment needs to be available. Access becomes more important than choice'* (Private clinic Nurse)

Another member of staff perceived that although numbers of services were (in one sense) healthy, he also articulated the 'revolving door' scenario that went hand-in-hand with choice of alcohol service provision:

> *'I may go to one service and don't like it, and then go onto the next one. It's a revolving door spinning people from one service to the next. Five services are being funded by the PCT and one patient could be getting five services. The system is untracked and un-audited'* (Private clinic Therapist)

There are a number of differing treatment philosophies around problem drinking but there is no evidence to suggest that one approach leads to better recovery (Raistrick, Heather & Godfrey, 2006). The different treatment approaches have helped to create a 'revolving door' that enables problem drinkers to access numbers of different service and a lack of systems and processes within alcohol treatment services to measure patient progress allows this multiple access.

Processes and measurements of service delivery

Shortcomings on process and measurement of alcohol treatment services occur at a national and local level. A review of alcohol services in England and Wales (Prime Minister's Strategy Unit, 2004) concluded that the system is confusing to enter with little referral between one part to another. The traditional role of the GP as gatekeeper to specialist services does not perform this function in alcohol treatment, and there are a number of inconsistent practices and systems across the whole treatment arena. Within the NHS clinic, auditing and measurement of service delivery appeared vague with inconsistency of approach and little emphasis on measurement as a core or meaningful activity. A member of the healthcare team acknowledged that *'we need to be more constructive in measuring the service'* (NHS Ward Manager). Some members of the healthcare team had personal outcome measurements; *'for me personally it's about someone in a drinking crisis working towards resolving that'* (NHS Consultant).

Statistical measurements such as waiting times were not perceived as capturing the essence of the work of the NHS clinic. Although waiting times were within Government guidelines, they were not perceived as a measurement of service delivery as commented by a member of staff:

> *'Statistics do not tell us whether [the patients] still have problems; there is no quality of life measurement'* (NHS Nurse).

In comparison, the private treatment clinic had a number of management processes in place; a 'pre-admissions process' for NHS-funded patients, a patient feedback process, processes for audit and monitoring of practices, and processes for measurement of patient treatment outcomes.

For NHS funded patients at the private clinic there is a strict admissions process, which is established by the PCT and involves a waiting time of at least six weeks. The staff perceived that their waiting list for NHS patients was 'healthy'. *'It's important for us to have the pre-admissions process as it proves motivation by the patient'* (Private clinic Nurse*).* However, patients did not share the 'healthy' waiting list view and perceived that:

> *'The waiting list is too long. If you go privately, you are in within a few days but you can be waiting two months by the NHS and when you are desperate it's a long time'* (Private clinic NHS funded patient, female, 41 years).

For privately funded patients there are no such admission criteria. A private patient can access the clinic as described by one private patient merely by *'getting your wallet out and paying. I am fortunate to be able to do that.'* (Private clinic patient, male, 41 years).

The PCT have established strict criteria for NHS patient access to private sector clinics in that such funded patients can only access the private clinic service twice yet there are no such criteria for patient accessing NHS alcohol services. There are no defined pathways for GP referral onto alcohol treatment services and no monitoring or a database of problem drinkers from one service to the next. There are also distinct differences between the NHS service and the private clinic on how service delivery is managed. The private sector clinic audit and measure all aspects of their treatment service from waiting times through to patient outcomes at six monthly intervals but the NHS audit is limited and ad hoc in its approach.

Discussion

A number of clear themes influencing service quality emerged from this study. An overarching theme throughout this study was the differing interpretation of what service quality means to the different stakeholders. The findings from this study suggest that problem drinkers perceive that service quality in NHS alcohol treatment services is delivered through a good standard of clinical care and by an empathetic relationship with their service providers. The attributes that patients articulated as key to the relationship with the healthcare team, were those of trust, helpfulness, understanding, responsiveness, reliability, and non-judgmental and these attributes relate to four of the five service quality dimensions of the service quality model detailed in Figure 1. Of lesser importance was the physical environment and facilities of the NHS clinic, which relates to the

tangibles service dimension. However, this study suggests that there is a lack of service quality processes and measurement in NHS alcohol treatment services and a lack of investment.

Accountability for service delivery differed between public and private sector providers. The director of the private clinic is accountable to a number of stakeholders; the owners of the clinic group to deliver a profitable service; the Healthcare Commission for maintaining appropriate professional standards; and to the PCT who fund seven NHS beds, for delivering a service to a set of specified criteria and within an agreed cost. Accountability in the NHS service appeared to focus primarily on delivery of clinical care.

Within the private clinic, the abstinence-based treatment programme had a defined set of processes, systems and outcomes that has produced service provision based around attributes of process, professionalism, and profit. Patients expressed service quality expectations of achieving sobriety, recovery, and receiving a professional service. The private clinic appears to deliver service quality to many of the specifications of the NHS quality agenda in terms of evaluation capabilities and performance measures, which were not in evidence in the NHS alcohol service. However, there appeared to be an empathy gap between the staff and patients within the private clinic that was not apparent in the NHS clinic.

The main factors influencing the service expectations of problem drinkers were their personal need for treatment and past experience of services. These are two of the four factors of the service quality model (see Figure 1). An additional factor that emerged from the study was the range and level of services that problem drinker can access. People often become problem drinkers because of the bad choices they have made in their lives and providing extensive choices in treatment services may not helpful to either the service provider or the problem drinker. This choice creates a 'revolving door' practice enabling problem drinkers to move from one treatment service to another and re-access the services again and as the statutory service the NHS believes it has a moral duty to keep their door open. Whether choice can improve quality in healthcare is debatable and it can potentially undermine equity as there will always be people better equipped to make choices than others. The revolving door of alcohol treatment services

has emerged partly as a result of inadequate processes and measurement in the service provision as responsibility for the services is fragmented with no single body or authority with either the power or the purse strings to effect or organise change.

Shortcomings on process and measurement of alcohol treatment services occur at a national and local level. There are also a number of inconsistent practices and systems across the whole treatment arena. The PCT has established a stringent set of criteria for NHS patient access to the private treatment clinic yet there are no such criteria for entry to NHS services. The private clinic implements strict criteria for treatment for NHS patients yet have no criteria for private patients other than the ability to pay. There are no defined pathways for GP referral onto any tier of alcohol treatment services and no monitoring or a database of problem drinkers from one service to the next. The conclusions drawn from this study are backed up in the wider literature on alcohol treatment services with the service provision deemed patchy with very few shared objectives or performance indicators and little capacity to tackle problem related drinking coherently (Prime Minister's Strategy Unit, 2004).Establishing relevant service quality measurements for problem drinking is difficult as treatment outcomes are not precise and performance indicators such as waiting times can be meaningless.

The findings from the research suggest that improvements to alcohol treatment services are needed. What should be considered is a grass root assessment of local alcohol services along with a system for the commissioning of all treatment services. There is also a need to develop a framework for the Primary Care Trusts to plan local services more effectively and consider the appropriate level of funding for these services. Measurements of performance need to be introduced into NHS treatment services focusing on the appropriateness of the treatment and tracking the progress of the patient through the treatment system. Private sector healthcare staff need to look beyond the treatment process and develop more awareness of a patient's individual needs. This study also identified a need for local services to work constructively together rather than perceive themselves to be in competition for vulnerable patients such as problem drinkers.

There are evidently some limitations of the present study. This was a small scale study limited to two treatment centres within one UK city. There is also the issue of

subjectivity in perceptions based research and the difficulties in establishing independent objective measures. In addition there are also methodological difficulties associated with conducting research amongst this particular group, namely reliability of data from respondents with long-term drinking problems. However, to date there has been little research on the service quality delivery of alcohol treatment services and despite the significant cost of £1.7 billion per annum to the NHS arising from alcohol misuse, there is a gap in the literature in defining and identifying how service quality can be delivered in NHS alcohol treatment services. Although this paper has attempted to start to fill this gap and draw attention to the need for further research in this field there is scope for investigation into service quality delivery into alcohol treatment services in other geographical locations, comparisons with services in other countries and of growing importance in the UK as increased levels of female problem drinkers emerge, gender issues within the service provision.

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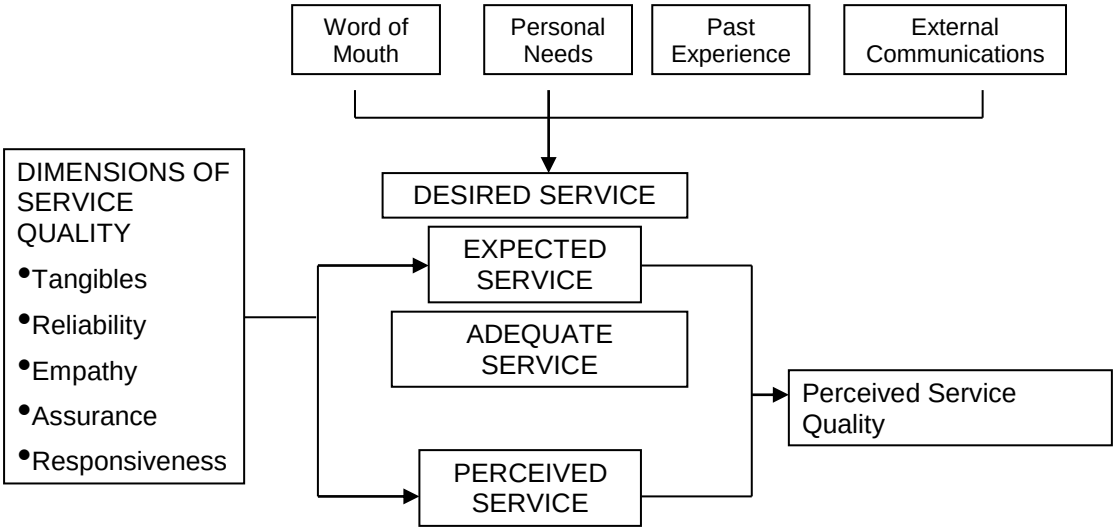
Figure 1: A Conceptual Model of Service Quality



Source: Parasuraman, *et al* (1985)

Appendix 1 Topic guides for participant interviews on whether the treatment clinic delivers a quality service to patients

- What does a quality service mean to you?
- What do you think are the criteria for a quality service in the clinic?
- Who do you think decides whether the service is good or not?
- Who do you think judges whether a good service has been delivered?
- Are systems in place to deliver a quality service? What are these?
- Are practices in place to deliver a quality service? What are these?
- What are the gaps in the service provision?
- Who is important in the service delivery process?
- What do you think about the service overall?