

# Clinic Compare Brief

Prepared for Andrew — 29 April 2026

**Market data correct as of 29 April 2026. UK private rehab is a moving market; clinical leads, ownership, CQC ratings and prices change. Verify with the clinic before booking.**

partner.guide · Confidential to Andrew · 29 April 2026

**Confidentiality.** This brief was written for a single buyer. It is not for redistribution. The clinical information about the patient described here is held only in the writer's possession and is destroyed at delivery.

## Executive Summary

### What you described.

Your partner contacted me on behalf of Andrew, 47, a partner at a City law firm regulated by the SRA. Andrew has been drinking daily for nine years, currently around two bottles of red wine per night, with the volume escalating in the past eighteen months. He is also managed on sertraline 100mg for depression — no prior psychiatric admissions, no prior residential treatment. The firm is not aware of the situation. There can be no insurance claim and no administrative record that connects Andrew's name to any clinic. Andrew has agreed to a residential admission after Christmas. Your partner wants a shortlist before that conversation has to be done under pressure.

### What this brief recommends.

Two clinics fit this situation well given the constraints as you have described them. Clinic A, a well-known independent provider in Cheshire, and Clinic B, a major national chain with strong dual-diagnosis capability, are the two strongest fits. The deciding factor between them is the admissions route: Clinic A takes families direct, with no broker in the chain; Clinic B accepts both direct and broker referrals. For a buyer where the privacy need is SRA-grade, the route to the clinic matters as much as the clinic itself. Both clinics have the medical detox capability Andrew requires and fall within the £15–25k budget range for a 28-day stay.

### What this brief is deliberately not doing.

It is not recommending a specific clinic. That decision belongs to Andrew and his partner, ideally after an initial assessment call with both shortlisted clinics, with this document on the table. It is not clinical advice and does not replace a GP consultation or a pre-admission medical assessment. It does not call the clinic for you, negotiate terms, or act as an agent. It provides the comparison — the facts, the honest price band, the admissions route, the clinical model, and the questions worth asking before you commit. What you do with those facts is your call.

## How This Brief Was Made

### The criteria used — in order of weight, for this specific buyer

I ranked clinics against Andrew's situation in this order. The weighting is not generic; a different buyer with a different picture would produce a different ranking.

- **Medical detox capability for a daily drinker on sertraline 100mg.** At two bottles of wine per night for nine years, Andrew is at meaningful physiological dependency. Alcohol withdrawal at that level of consumption requires medical supervision — benzodiazepine-based detox protocol, a doctor on-site or on same-day call, and nursing observation overnight at minimum. Sertraline does not automatically complicate detox but the prescribing doctor needs to be involved. Any clinic that cannot confirm a medically supervised alcohol detox protocol with a named consultant physician is ruled out, regardless of price or location.
- **Budget fit at £15–25k for a 28-day stay.** This is a workable budget for most well-regarded independent providers and for the better units within national chains. It does not reach the premium end of the market (£35k and above) and I have not spent research time there. Any clinic whose published or confirmed price band sits materially above £25k for a standard 28-day admission is excluded unless there are compensating factors the buyer has specifically asked me to consider.
- **London-commutable for partner visits.** Andrew's partner has ruled out Scotland and wants to be able to visit at weekends without an overnight stay. The practical geography is: Cheshire is reachable (around two hours by train from Euston, or less from central London by car), the Midlands is reachable, the South and South-East is reachable. Scotland is not in scope for this buyer. I have included one Scottish clinic (Clinic C) in this brief specifically because it is one of the stronger clinical options in the market and I want Andrew's partner to understand what the Scotland constraint costs in clinical terms. That is a real choice; this brief does not make it invisible.
- **SRA-grade privacy from the firm.** Andrew is a partner at an SRA-regulated firm. The firm does not know. There is no insurance route and there can be no admin trail connecting Andrew's name to any clinic through a broker or insurer. This criterion rules out any clinic that primarily admits via broker referral where the broker's systems carry the patient's name, and it shapes how the admissions route question is framed on every clinic page below.
- **Dual-diagnosis awareness — depression managed with sertraline.** Andrew is not presenting an acute psychiatric emergency, but he is on an antidepressant, and alcohol at this volume consistently interacts with depression: the mood picture will not resolve cleanly in the first weeks of detox. A clinic that treats alcohol in a silo and has no on-site or closely affiliated psychiatric resource is a worse fit than one that has dual-diagnosis capability built in. This criterion is a tiebreaker at the shortlist stage, not a dealbreaker — but it is the right question to ask before booking.

### Clinics considered and ruled out

- **Clinic E — Devon coastal facility, independent, ~20 beds, strict 12-step model, no medical prescribing on-site.** Ruled out on two counts: the distance from London for partner visits is not workable at weekend frequency, and the no-prescribing model is the wrong fit for someone on sertraline who requires medically supervised detox. The 12-step structure is credible for the right patient; this is not the right patient for it in this clinical picture.
- **Clinic F — Central London outpatient and day programme, no residential beds.** Ruled out because Andrew and his partner have agreed the next step is residential. An outpatient programme is a real option for a different buyer; it is not what was asked for here. I note it exists because if the residential conversation breaks down, a structured day programme in London is worth knowing about.
- **Clinic G — South-East England, residential, broker-heavy, no direct admissions route available.** Ruled out primarily on admissions route: at SRA-grade privacy, a clinic that only admits via broker is a structural problem. I could not confirm a direct-family-referral route that bypasses broker systems.

Clinically, not a bad option; operationally, the wrong one.

- **Clinic H — Scottish residential specialist, strong medical and dual-diagnosis track record.** Distinct from Clinic C. Also ruled out because the partner has ruled out Scotland. Unlike Clinic C, Clinic H does not have the specific detox protocol strength to make the inclusion argument; Clinic C does, which is why Clinic C stays in the comparison as the what-you-are-choosing-against entry.
- **Clinic I — Northern England, chain-operated, strong volume, limited dual-diagnosis depth.** Ruled out because it falls inside the same geography window as Clinic B but without Clinic B's dual-diagnosis infrastructure. Where two chain-operated options are available at similar price and geography, I compare them and present the stronger fit; Clinic I did not make that cut.

### The clinics in this comparison

- **Clinic A** — well-known Cheshire provider, independent, approximately 28 beds, 12-step-influenced eclectic model, direct admissions only (no brokers).
- **Clinic B** — major national chain, multiple UK sites, strong dual-diagnosis capability, mixed admissions route (accepts both direct referrals and broker referrals).
- **Clinic C** — Scottish clinical specialist, smaller (~16 beds), strong medical detox capability, direct admissions only. Included here because Scotland was ruled out by Andrew's partner — and the brief should show what that constraint costs.
- **Clinic D** — Southern-England private hospital with a dedicated addiction wing, premium price band (£35k and above for a 28-day stay), broker-heavy admissions model.

## Clinic A – well-known Cheshire provider

### What it is

An independent residential provider in Cheshire, established for more than two decades, currently operating around 28 beds across two or three interlinked buildings on a single campus. It is not part of a chain; it has a named founder-clinical-lead structure that has remained largely stable. In the market, it is well-regarded and well-known – it is often the first name a London family hears when they start asking around.

### Clinical model

**Detox:** Medically supervised alcohol detox using a benzodiazepine protocol (chlordiazepoxide taper is the standard approach for alcohol dependency; the clinic's published model is consistent with NICE CG115). A named consultant physician oversees detox. Nursing is present overnight. For someone at Andrew's consumption level, you should expect five to seven days of supervised detox before the therapeutic programme begins.

**Therapeutic model:** 12-step-influenced but not rigidly 12-step. The programme draws on CBT elements, group therapy, and 12-step principles without requiring 12-step participation as the exclusive framework. In practice, the 12-step culture is present in the building; a buyer who finds that register hostile should raise it at the assessment call.

**Dual-diagnosis:** The clinic has a consulting psychiatrist who attends the site on a scheduled basis – typically two or three times per week in the standard model. This is adequate for Andrew's picture (depression managed on sertraline, no prior psychiatric admissions) but it is not the same as an on-site dual-diagnosis team. The question to ask (see below) is whether the psychiatrist's scheduled sessions include a pre-admission assessment, or only the in-programme review.

**MAT:** Medication-assisted treatment for alcohol – naltrexone, acamprosate – is available post-detox for appropriate candidates. This is not universally offered at independent providers; Clinic A's model includes it. Worth confirming the pathway at assessment.

### Honest price band

A 28-day residential admission is typically in the range of £14,000–£19,000 for the standard programme. This sits within Andrew's budget. What is usually included: the accommodation, all meals, the supervised detox (medication included), the therapeutic programme, and the initial family session. What is typically not included: one-to-one therapy beyond the standard programme allocation (often charged at £100–£150 per session if added), the pre-admission medical assessment (sometimes charged separately at £200–£400), and any specialist investigations if indicated during detox (bloods, imaging – rare but billed separately). Extensions beyond 28 days are available at a daily or weekly rate; the first conversation should establish what that rate is before admission.

### Admissions route

**Direct.** Clinic A does not work with brokers and does not pay referral fees. Families and individuals contact the admissions team directly, or are referred by a GP or other clinician. **There is no third-party finder's fee embedded in the price you pay.**

This matters for Andrew: the direct route means the only record of the referral is between the buyer's contact details and the clinic's admissions file. No broker database. No referral-management system operated by a third party. The verification question to ask in writing: *"Do you pay any referral fee, finder's fee or commission to any third party for my admission?"* Get the answer in writing before you give your name to the admissions process.

### Who it tends to fit

Buyers who want an established, independent, non-chain environment. Professionals in their 40s and 50s, often referred by someone who has been through the clinic themselves or knows someone who has. People who want a named, accountable clinical structure rather than a corporate brand. The Cheshire geography means it draws from the North-West but also from London buyers who want distance from their professional environment.

### Who it tends not to fit

Buyers who need a higher level of dual-diagnosis psychiatric resource on-site. Buyers who find 12-step culture uncomfortable and are not prepared to engage with it at all — the culture is present, even where it is not mandated. Buyers whose drinking pattern includes significant other substance use alongside alcohol (Clinic A's model is primarily structured around alcohol and in some cases prescription medication; a poly-substance picture may be better served by a unit with broader addiction medicine depth). Buyers who need to be within an hour of London; Cheshire is achievable but it is not a short drive.

### What I'd want to know before booking

- **"What is the psychiatrist's specific involvement for a patient arriving on sertraline 100mg — is there a pre-admission assessment, and is the prescribing question reviewed before detox begins or only after?"** The clinic's model has a consultant psychiatrist on scheduled visits. The question is whether Andrew's SSRI is actively managed from day one of the detox or reviewed only once the detox has completed. These are materially different protocols and the answer should be specific, not reassuring.
- **"Can you describe the 12-step programme component in concrete terms — how many meetings per week, is attendance mandatory, and what happens if a patient finds the framework unhelpful?"** The eclectic-plus-12-step marketing covers a wide range of actual practice. You want to know whether the 12-step element is a structured part of the programme or an available-but-optional addition. The answer determines whether the cultural fit is right for Andrew.
- **"What is your after-care provision for the 12 months following discharge — is there a named after-care coordinator, are there scheduled check-ins, and is this included in the admission fee or billed separately?"** The single most under-scrutinised element of any residential admission is what happens after the 28 days. Relapse in the first 90 days post-discharge is the norm, not the exception. The after-care provision is often where independent providers are weakest.
- **"If Andrew's detox requires more than seven days — say, a complicated withdrawal or a slower taper — does the 28-day programme clock start from the end of detox or from the date of admission?"** This is a price question disguised as a clinical question. If the 28-day programme starts from the admission date and the first seven are detox, Andrew gets 21 days of therapeutic programme. If it starts from the end of detox, he gets 28 days. The difference is material and the answer is not always in the brochure.

### Source notes

Information drawn from: the clinic's published programme description and admissions literature; NICE CG115 (Alcohol-use disorders: diagnosis, assessment and management, last reviewed July 2019) for the detox protocol standard; the Care Quality Commission's inspection report for this provider (inspection date and rating to be confirmed and cited in the bespoke brief for this buyer — the sample brief uses anonymised descriptor; the real brief will cite the report directly). James Roberts's knowledge of this provider's clinical structure, drawn from five years of independent sector monitoring. No anonymous patient quotes. No claims about named clinical staff.

## Clinic B – major national chain

### What it is

A national chain with multiple residential sites across England, operating under a single corporate brand with shared clinical governance. The scale means consistent standards across sites and a centralised admissions function; it also means the experience has less of the named-founder character of an independent. The specific site relevant to Andrew – within commutable distance of London – is a mid-sized residential unit, well-staffed, with a specific dual-diagnosis pathway that distinguishes it from smaller independent providers.

### Clinical model

**Detox:** Full medical detox capability. The chain employs addiction-medicine consultants and maintains clinical oversight to a standard consistent with or above what most independent providers offer. At the volume of Andrew's consumption, the detox will require medical supervision; the chain's protocol is well-established and CQC-reviewed.

**Therapeutic model:** Primarily CBT-based, with trauma-informed elements in the dual-diagnosis pathway. Less 12-step culture than Clinic A – the group therapy structure is psychotherapeutically oriented. For a buyer who is wary of the 12-step register, Clinic B's model is a more neutral fit.

**Dual-diagnosis:** This is Clinic B's comparative strength in this shortlist. The chain has on-site or closely affiliated psychiatric cover, a dedicated dual-diagnosis pathway, and a protocol for patients arriving on prescribed psychiatric medication. For Andrew – on sertraline, with a depression picture that will need monitoring during detox and the early programme weeks – this is the most relevant capability difference between Clinic A and Clinic B.

**MAT:** Post-detox medication-assisted treatment is standard on the pathway. The chain's prescribing protocols are documented and consistent across sites.

### Honest price band

A 28-day residential admission at the relevant site is typically in the range of £16,000–£22,000 for the standard programme. This sits within Andrew's budget, with room at the top of the range. What is included is broadly similar to Clinic A: accommodation, supervised detox, the therapeutic programme, a family session. What is less consistent on chain pricing: one-to-one therapy allocation varies by site and by the specific programme stream the patient is placed on. The pre-admission assessment is usually included in the total price for this chain (confirm at booking). Extensions are available; ask for the daily rate in writing before admission.

### Admissions route

**Mixed.** Clinic B accepts both direct referrals (from families, GPs, and individuals) and referrals via third-party broker firms. **If you arrive via a broker, a referral fee – typically £1,500–£3,000 – is embedded in the price you pay for the admission. You do not see this fee separately; it is built into the clinic's billing.** If you arrive direct, that fee is not in play.

For Andrew, the instruction is clear: go direct. Do not use a broker to reach Clinic B. Contact the chain's admissions team directly, state you are a self-referral or family referral, and confirm in writing that the admission will not involve a third-party referral fee. The verification question to ask in writing: *"Do you pay any referral fee, finder's fee or commission to any third party for my admission?"* Get the answer in writing.

The mixed admissions route is common in chain operators because the broker network is a significant volume driver. It does not make Clinic B a worse clinical option. It does mean the admissions route requires active management for a buyer in Andrew's privacy position.

### Who it tends to fit

Buyers who want the clinical depth of a dual–diagnosis pathway alongside alcohol treatment. Buyers who are less comfortable with a 12–step therapeutic culture. Professionals who respond better to a CBT–structured framework and a clinical, evidence–based register. Buyers who want the assurance of CQC inspection at multiple sites rather than a single site's track record.

### Who it tends not to fit

Buyers who specifically want the named, independent, non–corporate environment of a founder–led clinic. Buyers for whom the chain's scale reads as impersonal — the admissions process for a large chain can feel more procedural than a smaller independent. Buyers who need a very particular geographic placement (the chain's sites are not evenly distributed; proximity to a specific city depends on which site is relevant).

### What I'd want to know before booking

- **"Which site within the chain is being proposed for this admission, and can you confirm the CQC inspection rating and date for that specific site — not the group's overall rating?"** National chains can have strong central governance and variable site performance. The CQC inspection report is the document that tells you which site has the better record. Ask for the specific site's inspection report, not a group summary.
- **"What is the dual–diagnosis pathway concretely for a patient on sertraline 100mg presenting with alcohol dependency — is there a named psychiatrist attached to this patient's case from the pre–admission assessment onwards, or is the psychiatric resource a shared resource available on request?"** This is the question that separates a genuine dual–diagnosis capability from a dual–diagnosis marketing claim. A named psychiatrist from pre–admission is materially different from a shared resource available on escalation.
- **"Can you confirm in writing that this admission is a direct referral with no third–party referral fee, finder's fee or commission paid to any broker or third party in connection with my booking?"** Get this in writing before giving Andrew's name to the admissions system. A chain that uses a mixed admissions model has broker relationships; you need written confirmation that your specific referral is outside that channel.
- **"What is the one–to–one therapy allocation per week in the standard programme — hours per week, type of therapy, and is there a named therapist assigned from day one?"** Chain operators vary significantly on this. The headline programme description often says "individual therapy included" without specifying frequency. For a patient with a depression picture and nine years of daily drinking, the therapeutic intensity matters.

### Source notes

Information drawn from: the chain's published programme descriptions and admissions literature across its network; the Care Quality Commission's inspection records for relevant sites (inspection dates and ratings to be cited in the bespoke brief); NICE CG115 for detox protocol standard; James Roberts's independent knowledge of this chain's clinical governance and dual–diagnosis pathway, drawn from sector monitoring. No anonymous patient quotes. No claims about named clinical staff.

## Clinic C – Scottish clinical specialist

### What it is

A smaller residential clinical specialist operating in Scotland, approximately 16 beds, with an explicitly medical and psychiatric orientation that distinguishes it from the predominantly therapeutic models of most UK private providers. The unit has a strong record on complex detox and on dual-diagnosis presentations. It is included in this brief because it is one of the strongest clinical fits for Andrew's profile in the UK market – and because Andrew's partner has ruled out Scotland. That ruling should be a considered choice, not an invisible default.

### Clinical model

**Detox:** Clinic C's strongest comparative advantage. The unit operates a consultant-led medical detox with a higher level of clinical oversight than most independent providers – a consultant physician is available on short notice, nursing cover is available around the clock, and the detox protocol is documented to a clinical standard consistent with specialist NHS settings. For someone at Andrew's consumption level with a concurrent SSRI, this is the highest-confidence detox environment in this shortlist.

**Therapeutic model:** Structured around evidence-based individual therapy and small-group work, with a clinical rather than 12-step orientation. The model is closer to a private psychiatric unit's approach than a traditional rehab programme culture. For a patient who is sceptical of group therapeutic formats, this is worth noting.

**Dual-diagnosis:** Strong. The unit has on-site psychiatric resource and treats comorbid depression as part of the programme rather than as an add-on referral. For Andrew's picture – established depression on sertraline, nine years of daily drinking – this is a materially better dual-diagnosis environment than Clinic A and at least equivalent to Clinic B's pathway.

**MAT:** Available and actively used within the programme for appropriate candidates. Post-detox prescribing is managed within the clinical team rather than referred out.

### Honest price band

A 28-day admission typically falls in the range of £18,000–£24,000 at the standard clinical pathway. This sits within Andrew's budget but at the upper end. The clinical depth is reflected in the price – the consultant physician hours and nursing intensity cost more than a lower-acuity residential programme. What is included: detox, all clinical supervision, the therapeutic programme, meals and accommodation. After-care provisions are built into the programme more systematically than at most independent providers.

### Admissions route

**Direct.** Clinic C does not work with brokers. Referrals come from GPs, psychiatrists, families, and individuals directly. No third-party finder's fee. The verification question still applies: confirm in writing before giving patient details.

### Who it tends to fit

Buyers who want the highest level of medical and psychiatric oversight for a medically complex presentation. Buyers for whom dual-diagnosis is the central clinical question rather than a secondary one. Buyers where the preference is for a clinical, evidence-based model over a therapeutic or 12-step environment. Buyers who can reach Scotland without difficulty and for whom the geography constraint does not apply.

### Who it tends not to fit

**This buyer.** Andrew's partner has ruled out Scotland, and that ruling holds. Clinic C is included here not to override that decision but to make it visible: the clinical quality at this unit is high, the admissions route is

clean, and the price sits within budget. If Andrew and his partner revisit the geography constraint — for any reason — Clinic C should come back into the conversation. The constraint is theirs to hold or release; the brief's job is to make sure it is a real choice.

Beyond geography: buyers who specifically want a social, group-centred residential programme culture will find the clinical orientation of Clinic C quieter and more medical in feel. The programme is structured; it is not the immersive peer-group experience some patients need.

### What I'd want to know before booking

- **"What is the specific travel and logistics pathway for a London-based family — what does the admission day look like, and what is the nearest airport or train station with reliable connections?"**

This question is not about geography suitability (which is settled — Scotland is ruled out); it is the question that opens the door if Andrew and his partner want to revisit. Having the operational answer means the re-evaluation, if it comes, has the right information.

- **"How does the programme handle the interaction between the sertraline and the alcohol detox — is the prescribing psychiatrist involved from the pre-admission assessment, and what is the protocol if the sertraline needs adjustment during detox?"**

The SSRI management question is more material here than at Clinic A or B because the unit's clinical depth means the answer should be more specific. Use this question as a calibration tool: a clinic with genuine dual-diagnosis capability gives a precise answer; a clinic with marketing-level dual-diagnosis capability gives a reassuring but imprecise one.

- **"What is the average length of stay for patients presenting with alcohol dependency and comorbid depression — and how many of your current 16 beds are occupied by this presentation type?"**
- Clinic C's small size means the ward environment is shaped significantly by the current patient mix. A unit with 16 beds where most are dual-diagnosis presentations looks and feels different from one where most are alcohol-only. The answer gives a sense of the clinical culture Andrew would be entering.

- **"What does your after-care provision look like for a London-based patient returning to a City professional environment — are there London-based resources within your after-care network, or does after-care function primarily for patients who remain in or near Scotland?"**
- After-care infrastructure for a London professional is a practical question for any Scotland-based unit. The answer may be strong — video-based follow-up, London partner organisations — but it needs to be asked and documented.

### Source notes

Information drawn from: the clinic's published clinical model and admissions literature; CQC equivalent regulatory inspection (for Scottish providers: Healthcare Improvement Scotland inspection records — citation to be confirmed and included in the bespoke brief); NICE CG115; James Roberts's independent knowledge of this unit's clinical orientation and reputation in the sector. No anonymous patient quotes. No claims about named clinical staff.

## Clinic D – Southern-England private hospital

### What it is

A private hospital in Southern England with a dedicated addiction wing operating as a semi-autonomous unit within a broader psychiatric and mental health hospital. The setting is more clinical than residential in feel – closer to a private ward than a countryside retreat. The addiction wing operates a high-acuity model; the hospital has full acute psychiatric cover available if required.

### Clinical model

**Detox:** Full medically supervised detox, consultant-led, with acute hospital backup if the withdrawal picture becomes complicated. In terms of raw medical safety, this is the highest-acuity environment in the shortlist for managing a difficult detox.

**Therapeutic model:** Primarily individual therapy, CBT and psychodynamic orientations depending on the patient's picture. The group element is present but the hospital setting means the communal therapeutic culture of a dedicated residential rehab is less pronounced. For a patient who is a senior professional and specifically uncomfortable with group therapeutic settings, the hospital model may feel more manageable.

**Dual-diagnosis:** Full psychiatric cover on-site. Not a specialist dual-diagnosis pathway in the same sense as Clinic C, but acute psychiatric resource is immediately available rather than on a scheduled-visit basis. The distinction matters if the presentation becomes more complex during the admission.

**MAT:** Available within the hospital's prescribing framework. Post-detox medication is managed within the psychiatric and addiction medicine team.

### Honest price band

A 28-day admission at the standard pathway is typically £35,000–£45,000. This is materially above Andrew's stated budget of £15–25k. **Clinic D is included in this brief not as a recommended option for this buyer but to provide a clear view of the premium end of the market and why this brief has not recommended it.** The additional £15,000–£20,000 above Clinic A or B buys acute hospital backup, a higher ratio of individual to group therapy, and the private hospital physical environment. For the clinical picture Andrew presents – a physically healthy 47-year-old with established alcohol dependency and managed depression, no acute medical complications – that premium is not clinically indicated.

If the buyer's budget changes, or if a pre-admission medical assessment reveals a more complex clinical picture that warrants hospital-grade backup, Clinic D moves up the ranking. On the information available, it does not.

### Admissions route

**Broker-heavy.** Clinic D admits the majority of its addiction-wing patients via third-party broker referral. Direct family referrals are technically available but the admissions process is oriented around broker relationships. **A broker-route admission embeds a referral fee – typically £1,500–£3,000 – in the price you pay. For an already above-budget admission, this compounds further.** More significantly, for Andrew: broker systems carry the patient's name and referral details within third-party databases. For an SRA-regulated professional with a firm-privacy requirement, this is an operational problem independent of cost.

The verification question applies here with greater urgency than for any other clinic in this brief: *"Do you pay any referral fee, finder's fee or commission to any third party for my admission?"* Ask before giving a name. If the honest answer is that the broker route is the default, this clinic is the wrong choice for Andrew regardless of clinical quality.

### Who it tends to fit

Buyers at the premium end of the budget range who specifically want a private hospital environment rather than a residential rehab. Buyers with very high clinical complexity — severe comorbidities, prior detox complications, acute psychiatric risk — where the hospital's acute cover is a genuine safety requirement rather than a comfort premium. Buyers who have been advised by a consultant physician that hospital-grade medical backup is appropriate for their detox.

### Who it tends not to fit

This buyer. The price is above range, the admissions route is operationally problematic for Andrew's privacy requirement, and the clinical picture does not indicate a need for the acute hospital backup that justifies the premium. If Andrew's pre-admission assessment produces a more alarming clinical picture than currently presented — severe liver involvement, cardiac risk, prior seizures — the calculation changes. On the information available, Clinic D is the informed-exclusion entry in this brief.

### What I'd want to know before booking

- **"What percentage of your current addiction-wing admissions arrive via broker referral versus direct family or GP referral — and if I arrive direct, can you confirm in writing that no referral fee or commission will be paid to any third party in connection with my admission?"** For a buyer in Andrew's privacy position, this is the question that needs a written answer before anything else is discussed.
- **"What is the actual price for a 28-day admission at the addiction-wing standard pathway, inclusive of all fees — detox medication, consultant physician sessions, one-to-one therapy allocation, meals, accommodation — and what are the most common additional charges that appear on the final invoice?"** Premium pricing is often marketed at a headline number that excludes a material category of actual spend. At £35k–£45k as the entry point, the all-in figure and the bill-of-particulars are important to establish in writing before admission.
- **"For a patient arriving with alcohol dependency and a concurrent depression managed on sertraline — no acute psychiatric history, no prior admissions — what does the standard admission pathway look like, and is it the same pathway as for a patient with an acute psychiatric presentation?"** Private hospitals with mixed addiction and psychiatric intakes sometimes process both through the same intake pathway. The experience for a patient whose clinical picture does not warrant acute psychiatric management may be shaped by a setting calibrated for a more complex cohort.
- **"What is the physical environment of the addiction wing specifically — is it a separate building or corridor from the main psychiatric ward, and what does a typical day look like for a patient at day 10 of a 28-day stay?"** The hospital setting is a meaningful factor in fit. Some patients respond well to the clinical, structured environment; others find it alienating compared to the house-and-grounds model of a residential rehab. This question is worth asking honestly because the answer will confirm whether the physical environment fits Andrew.

### Source notes

Information drawn from: the hospital's published admissions literature and programme descriptions; CQC inspection records (inspection date and rating to be cited in the bespoke brief); James Roberts's independent knowledge of this unit's admissions model and sector position. No anonymous patient quotes. No claims about named clinical staff.

## Side-by-Side Comparison

The admissions route column is the one most buyers scan first and most comparison sources leave blank. This brief does not leave it blank. The two shortlisted clinics — A and B — are both within reach; the deciding factor between them is the dual-diagnosis depth (Clinic B is stronger on paper) weighed against the admissions-route management requirement (Clinic A is simpler for Andrew's privacy position because it has no broker route at all). That trade-off is the conversation to have at the assessment call.

Criterion	Clinic A	Clinic B	Clinic C	Clinic D
Setting	Independent, Cheshire, ~28 beds	National chain, multiple UK sites	Scottish clinical specialist, ~16 beds	Private hospital, Southern England, dedicated addiction wing
Alcohol detox capability	Yes — consultant-led, benzodiazepine protocol, overnight nursing	Yes — consultant-led, chain clinical governance, CQC-reviewed	Yes — highest medical intensity; consultant on short notice, 24-hr nursing	Yes — full medically supervised detox, acute hospital backup available
Dual-diagnosis handling	Consulting psychiatrist on scheduled visits (2–3×/week)	On-site or closely affiliated psychiatric cover; dedicated dual-diagnosis pathway	Strong — on-site psychiatric resource, dual-diagnosis treated as part of programme	Full acute psychiatric cover on-site; not a dedicated dual-diagnosis pathway per se
Therapeutic model	12-step-influenced eclectic (CBT elements, group therapy, 12-step principles)	Primarily CBT; trauma-informed elements; less 12-step culture	Evidence-based individual therapy and small-group work; clinical orientation	Primarily individual therapy (CBT and psychodynamic); lighter group culture
Price band (28-day stay)	£14,000–£19,000	£16,000–£22,000	£18,000–£24,000	£35,000–£45,000
Within Andrew's £15–25k budget?	Yes (at the lower end)	Yes	Yes (upper end; budget-tight)	No — above range
Geography (London-commutable)	Yes — Cheshire (~2 hrs by train)	Yes — relevant site within commutable range	No — Scotland ruled out by partner	Yes — Southern England
<b>Admissions route</b>	<b>Direct only — no brokers, no referral fee embedded in price</b>	<b>Mixed — direct AND broker; broker fee (£1,500–£3,000) embedded if via broker. Go direct.</b>	<b>Direct only — no brokers, no referral fee embedded in price</b>	<b>Broker-heavy — majority of admissions via broker. Direct route available but not default. Verify in writing.</b>
SRA-grade privacy	Yes — direct route, no third-party systems	Yes if direct; No if via broker	Yes — direct route, no third-party systems	Problematic — broker systems carry patient name
After-care included	Available; confirm inclusion and London-based resource at booking	Standard; confirm specific provision for London-returning patient	Systematic; confirm London-compatible resource	Available; confirm addiction-wing specific provision
<b>In scope for this buyer?</b>	<b>Yes — recommended</b>	<b>Yes — recommended</b>	No (geography)	No (price, admissions route)

The admissions-route row is one of the most-scanned and is the point most comparison sites cannot publish because they take broker money. This brief publishes it.

## What to Do With This Brief

### The next seven days — an order of operations

This brief is not an action plan. The decision belongs to Andrew and his partner. But the sequence below reflects the order in which the practical steps actually need to happen, and what tends to go wrong when they happen in a different order.

#### 1. Have the family conversation before ringing a clinic.

Andrew has agreed to a residential admission after Christmas. Before any clinic is contacted, the admission date and the arrangements around it need to be understood by both Andrew and his partner — not as a plan to be revealed to Andrew, but as a shared set of expectations. Clinics ask, in pre-admission calls, whether the patient knows they are being admitted and what the patient's current state of engagement is. The call goes better when the family has had that conversation first.

#### 2. Request an initial assessment call with both shortlisted clinics — Clinic A and Clinic B.

Both clinics offer an initial assessment call — no commitment, no charge, no name required beyond a first name and a contact email. The purpose of this call is not to sell you the clinic; the purpose is for the admissions clinical team to understand the presentation and confirm whether the clinic is the right fit. Go into the call with the four questions from each clinic's page above. Note the quality of the answer; the quality of the answer is diagnostic.

#### 3. Ask the admissions route question in writing before giving Andrew's full name.

For each clinic, before the admission process advances beyond an initial enquiry, send the following by email: *"Before I proceed with the admission process, I would like to confirm in writing: does your clinic pay any referral fee, finder's fee or commission to any third party in connection with this admission?"* Do not rely on a verbal confirmation. An email reply is sufficient; a written letter is better. This is not a hostile question — any reputable clinic will answer it clearly and without hesitation.

#### 4. Get a pre-admission medical assessment arranged.

At Andrew's consumption level and duration, the medically supervised detox is non-negotiable — both clinics on the shortlist provide it. But the pre-admission assessment is the point at which the clinic's medical team reviews Andrew's current health, his sertraline prescription, and the likely detox protocol. This should happen before the admission date is fixed, not on admission day. Both clinics can typically arrange this; confirm it is part of their standard intake process at the assessment call.

#### 5. Decide.

Between Clinic A and Clinic B, the deciding factor is this: if Andrew's depression picture requires active psychiatric management during the programme — not just a scheduled psychiatric visit, but a responsive, named psychiatrist involved from day one — Clinic B's dual-diagnosis infrastructure is the stronger fit. If the priority is the simplest possible admissions route with no broker infrastructure and no privacy complexity, and if the depression is well-managed on sertraline without recent escalation, Clinic A is the cleaner choice. Only the pre-admission assessment will resolve which of these descriptions fits Andrew's clinical picture more accurately.

### Crisis routes

This section is here by design, not as a formality.

If at any point before the planned admission Andrew presents signs of acute alcohol withdrawal — severe tremor, confusion, hallucination, seizure — this is a medical emergency. The planned residential admission is the wrong response. The right response is:

- **999** — medical emergency, ambulance
- **NHS 111** — urgent non-emergency clinical advice

- **A&E at the nearest hospital** — do not wait for a clinic admissions process to run if there is acute withdrawal risk

Samaritans — 116 123 (free, 24 hours, no charge, no referral needed) — if Andrew is in distress and the conversation needs to happen tonight rather than at an assessment call. These routes are free. They are not paywalled.

## How this brief was paid for

You paid £149. That is the only money in the system. No clinic in this brief paid for inclusion. No broker referred you to me. No commission is paid on any admission that results from this brief, in either direction. If a clinic mentioned in this brief later offers me money for inclusion, it is declined and recorded on the editorial standards page.

I have no financial interest in any UK addiction clinic.

**Written by James Roberts.** Sober since 1 June 2020, following residential treatment in 2020. Operates the partner.guide network independently. Former headhunter; no current employer, no panel, no retainer, no clinical qualification. Editorial standards — including the five published refund criteria, the same-day bypass policy, and the Annual Transparency Post audit — are at [partner.guide/editorial-standards](https://partner.guide/editorial-standards). Contact: [james@partner.guide](mailto:james@partner.guide).

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**SAMPLE** — illustrative descriptors used in place of named clinics. Your bespoke brief will name the clinics specifically. Order at [partner.guide/clinic-compare](https://partner.guide/clinic-compare) — £149.