



*National Treatment Agency
for Substance Misuse*

Improving the quality and provision of Tier 4 interventions as part of client treatment journeys

A best practice guide

September 2008

Reader information

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Lead authors	Colin Bradbury, Bill Puddicombe, Emma Christie
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1 Executive summary

Improving Tier 4 provision is a key part of the National Treatment Agency's (NTA) Treatment Effectiveness strategy. There is widespread agreement within the drugs field that, with a few notable exceptions, the relationship between commissioners, referring clinicians, users and carers and the providers of Tier 4 service provision can be improved.

This guidance summarises key challenges that currently face the Tier 4 sector. It links the roles that each stakeholder group can play in jointly finding solutions and improvements. This document can be read in tandem with Models of Residential Rehabilitation for Drug and Alcohol Misusers (NTA, 2006d), Drug Misuse and Dependence: UK Guidelines on Clinical Management (Department of Health (England) and the devolved administrations, 2007), and Commissioning Tier 4 Drug Treatment (NTA, 2006b). Reference should also be made to the World Class Commissioning Programme launched by the Department of Health in December 2007 (Department of Health, 2007). World Class Commissioning will deliver a more strategic and long term approach to commissioning services with a clear focus on delivering improved health outcomes. Many of the principles highlighted in this NTA best practice guidance, notably thorough needs assessments, partnership working and user involvement are reflected in the World Class Commissioning vision.

The target audiences for this guidance are commissioners and purchasers of drug services, providers of Tier 4 interventions, and user and carer groups.

This guidance does not seek to give technical, detailed guidance on possible solutions, but instead sets out the guiding principles on which local partners can seek to agree a way forward.

During 2008, NTA regional teams will be working closely with commissioners and providers to focus more attention and energy on improving this key part of local treatment systems through needs assessment and assistance in examining expanded commissioning options.

2 Introduction

Tier 4 interventions, as defined by Models of Care for Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006c – see Annex 1-3), form an integral part of locally commissioned drug treatment systems. However, Tier 4 service provision have not uniformly benefited from the improvement in capacity and quality experienced by community-based treatments since the launch of the first national Drug Strategy in 1998. In fact, the lack of effective Tier 4 commissioning processes and structures in some areas has resulted in impeded growth and a failure to guarantee income streams.

Improving Tier 4 provision is a key part of the National Treatment Agency's (NTA) Treatment Effectiveness strategy. Tier 4 service provision can provide effective responses to drug misuse in treating people whose use has been long and heavy, and people with complex needs, and they can enable drug users to move towards long-term abstinence when and where appropriate. Inpatient service provision can also assess and stabilise chaotic clients and certain Tier 4 service provision may also have an important role to play in diverting individuals away from long-term substance misusing careers by intervening early. In accordance with this, the NTA has already produced guidance on commissioning Tier 4 service provision, specifically the Models of Residential Rehabilitation for Drug and Alcohol Misusers (NTA, 2006d) and Commissioning Tier 4 Drug Treatment (2006b).

The National Institute for Health and Clinical Excellence published guidance on psychosocial interventions in drug misuse during 2007 and these highlighted the effectiveness of appropriate residential options.

This guidance is intended to provide a framework to enable local DAT partnerships to make further improvements to the commissioning and delivery of Tier 4 service provision for adult drug users in England. It should be read within the context of other published guidance as well as the guidance for local partnerships on user and carer involvement (NTA, 2007).

This guidance aims to look at the broad principles that underpin best practice in Tier 4 commissioning and delivery. It does not explore the technical aspects of commissioning in detail, but instead aims to address specific problems commonly reported in accessing and facilitating access to services. Given this topical approach, it is envisaged that this guidance will be regularly reviewed as the national picture changes and other work streams (such as the Healthcare Commission and NTA joint 2007/08 Improvement Reviews) come to fruition.

Note: Tier 4 comprises of two different but complementary categories of service provision as defined by Models of Care: inpatient treatment (IP) and residential rehabilitation (RR). Aftercare (AC) is a closely related category of service provision (see Annex 1-3 for definitions) This document seeks to be clear as to which type of provision is being referred to at any given point – denoted by IP, RR and AC. The term “Tier 4” is only used when the guidance could apply to all interventions. It is assumed that all references to Tier 4 provision will have due regard to integrated care pathways with Tier 3 or Tier 2 provision and with aftercare. Aftercare is not always residential and can take a range of different forms when delivered in a community setting.

In addition, may need to consider the wider context of mainstream health and social care commissioning initiatives when reading this guidance – notably the requirement of local authorities and primary care trusts to form health and wellbeing partnerships and carry out joint strategic needs assessments of their populations, in accordance with the Local Government and Public Involvement in Health Act 2007.

This document is based on the following principles:

- a Commissioning and provision of Tier 4 service provision needs to be evidence based, including ongoing local assessment of need, and reviewed regularly against clearly defined and agreed performance expectations.
- b Users are put at the heart of the Tier 4 commissioning process, both at:

- An individual level, with an agreed care plan (which includes aftercare) and consultation as to their treatment options – both in terms of modality or intervention and provider
 - A collective level, through the active participation of local user (and carer) groups and representatives, and the development of clear integrated pathways that link to published and widely publicised suitability criteria
- c Commissioners of different types of Tier 4 service provision (such as the NHS and local authorities) work together in close collaboration and under the strategic umbrella of the local Drug Strategy or drug action team (DAT) commissioning partnership (the body responsible for commissioning the overall treatment system for all of the people who are normally resident within its boundaries).
- d Local partnerships should review their current arrangements to ensure they are commissioning Tier 4 service provision in the most efficient way possible. Local commissioning partnerships may be able to increase efficiency by clustering together to jointly commission high-cost and low-volume service provision such as Tier 4 where this would provide opportunities for commissioning in a more co-ordinated and efficient fashion. This may be particularly useful in the commissioning of service provision for specific client groups, such as mothers of young children and dual diagnosis populations, and will ensure delivery of best value services with existing resources.

3 Current challenges in the commissioning of Tier 4 service provision

During 2007-08, the NTA (in partnership with colleagues from the Department of Health and Home Office) worked closely with the field to identify the challenges facing those commissioning, providing and using Tier 4 service provision. Listed below are some of the issues that have been commonly (although not universally) found and which this guidance seeks to address.

- a In a number of areas, there seems to be a lack of co-ordination and communication between joint commissioning groups at a strategic DAT partnership level, and social services community care managers at an operational level, with a large proportion of residential rehabilitation still being spot purchased rather than strategically commissioned. Despite the fact that there is general agreement that a collaborative approach between partnerships is likely to result in increased efficiency and improved quality, this is only practiced in a small number of localities
- b Criteria for accessing services can vary significantly across the country, with very robust and clear policies in some areas and ones that are fairly obscure or sporadically adhered to in others. Criteria in a given area can also be clearer for one form of treatment (such as RR) compared to others (for example IP and AC)
- c Individual Tier 4 services are often commissioned by a large number of DAT partnership areas. This results in different commissioning models (such as spot purchase vs. block contract) and service level agreements and monitoring requirements vary widely
- d Some Tier 4 treatment providers have historically been poor at returning National Drug Treatment Monitoring System (NDTMS) data as required, making it difficult to monitor activity and outcomes in an objectively comparable way. These problems will be compounded by the introduction of the Treatment Outcomes Profile (TOP) (Marsden *et al.*, 2007) as agencies failing to submit full NDTMS returns will not be able to evidence their contribution to effective client treatment journeys
- e There is a large degree of anecdotal evidence to suggest that much Tier 4 provision is purchased on a historical rather than evidenced basis, with some commissioners sometimes persisting with certain providers simply out of habit. This carries a number of risks, such as clients being referred to services that are unable to meet their needs, and that consequently Tier 4 provision will not represent value for money.
- f Integrated care pathways between community drug treatment and residential service provision are sometimes poorly defined or adhered to
- g In some areas of the country, there have been problems reported around a lack of co-ordinated post-discharge aftercare (for planned or unplanned discharges) when clients choose to remain in the areas where treatment services are located, as opposed to the areas from which they were resident prior to their referral being made. This can create significant pressure on local community drug providers and criminal justice agencies, as well as wraparound service provision (such as housing and health services)
- h Commissioners and services have been slow to develop provision in a way that users and carers consistently say they want. Perhaps the best example of this is using Tier 4 as a last resort, rather than as a concerted attempt to achieve long-term abstinence earlier in a drug-using career. This has led to unsatisfactory outcomes for all involved
- i Some providers (especially non-NHS) report the need to chase up invoices, placing an unnecessary drain on staff resources. Conversely, there have been a number of instances recently where providers have taken referrals from a third party in the knowledge that individuals do not have their funding secured. They then invoice the client's DAT partnership of residence retrospectively for service provision that the DAT did not commission

- j Due to the proportionately low numbers of individuals for whom DAT partnership areas will commission Tier 4 service provision, there is an inherent tension for individual DAT commissioners being able to devote adequate time to ensuring that they are commissioning the most appropriate and effective service provision
- k A national review of inpatient service provision published by the NTA in 2005 concluded that a majority of inpatient assisted withdrawal (55 per cent) was still taking place in non-dedicated units. While it is understood that a small number of clients may need specialist mental health input at the same time as their drug treatment, there is some evidence that clients who are treated in specialist drug settings are more likely to have a positive long-term outcome.
- l The Healthcare Commission and National Treatment Agency's joint Improvement Review for 2006/07 looked at commissioning across partnerships. One of the questions asked was:
"Were residential and in-patient services commissioned in line with national guidance?"
48% of the answers to this question were scored as "weak", indicating that this is an area that requires considerable and urgent attention for many partnerships. One of the main reasons that caused this was insufficient pathways in and out of Tier 4 service provision being specified in contracts.

4 Effective commissioning of Tier 4 service provision

4.1 Strategic commissioning

As DAT partnerships plan and oversee the commissioning of all drug treatment service provision for the residents of their areas, it is the responsibility of each DAT partnership to ensure that as part of its routine commissioning cycle and adult drug treatment planning process that the following issues are addressed.

4.1.1 Local assessment of need for Tier 4 service provision

The NTA's Needs Assessment Guidance (NTA, 2007b) sets out a suggested process and methodology for DAT partnerships to identify (and therefore to base planning decisions on) the level and type of Tier 4 service provision their residents (including offenders) are likely to require throughout the financial year. Partnerships will want to use the best available information and intelligence – from national, regional and local sources – to inform their commissioning practice. This includes separating out the required amount of stabilisation and assessment IP service provision as opposed to other Tier 4 service provision that are aimed at facilitating long-term abstinence and often (but not always) an exit from the treatment system.

A number of DAT partnerships make greater use of community-based alternatives to Tier 4 service provision, sometimes referred to as “community rehabilitation”, “community detoxification” or “Tier 3 abstinence service provision”. While such services may have their place within a modern treatment system, commissioners and other stakeholders must be clear about the roles and target client groups of such services. When commissioning tier 4 service provision partnerships consideration should be given to the available evidence for effectiveness. This can then be compared with the evidence of the efficacy of any community-based alternatives to Tier 4 service provision, while also giving due consideration to client choice.

In some cases residential rehabilitation may be the appropriate treatment modality for an individual specifically because it involves accommodation. In situations where clients are without stable housing, they may benefit from the increased stability of the residential service. Clearly this will only be effective if consolidated by resettlement provided either by the service or other elements of the partnership.

Note: In areas where Tier 4 provision has not traditionally been a widely available option, low take-up of services may have been misinterpreted as a lack of need. By the same token, a significant level of unmet need may be uncovered as a result of the promotion of Tier 4 treatment options following years of these services being seen by clients (and perhaps referrers) as not available or too difficult to access. Following an assessment of local need, thought should be given locally as to how a transition from very little or no provision being available, to proper availability (as defined by Models of Care (NTA, 2006c) can be best managed and how this links to evidence and outcomes.

4.1.2 Involving users and carers in the commissioning of Tier 4 service provision

It is good practice for all DAT partnerships to have robust and varied consultation links with individual service users and user representatives. It is good practice to have the active involvement of service users who may wish to access Tier 4 service provision enshrined in the commissioning of local assessment and care pathway procedures. In addition, it is recommended that user and carer representatives and forums are involved in the strategic planning and review of Tier 4 provision. See section five of this guidance for further information.

4.1.3 Block contracting

Once a DAT partnership has identified its likely local need and has agreed commissioning plans for this sector (taking into account the competing priorities and demands from other parts of the local treatment system), it is good practice to actively consider the agreement of block contracts with preferred providers (see Commissioning Tier 4 Drug Treatment (NTA, 2006b) for further details).

Block contracting can deliver stability and predictability to providers as well as potential economies of scale for DAT partnerships. Partnerships within a certain geographical area may wish to consider collaborating to achieve greater consistencies and economies of scale, as long as elements of client choice are preserved. This approach has the advantage that the establishment of the choice of service provision available (those that fit with an agreed list of quality and cost criteria) and the design contracting mechanism need only be carried out once. Partnerships can derive this kind of benefit from collaborative work without pooling funds.

One of the key advantages of block purchasing is the opportunity, while taking up a share of risk with providers, to mould the service to identified need. In offering block contracts commissioners should look to commission provision that meets specific local needs, via a detailed specification, rather than simply selecting from services on offer. Contracts may be designed to reflect a requirement for this specification to be met. Commissioners must also consider referral routes for block-contracted Tier 4 service provision, ensuring that these are well publicised and straightforward to navigate. This will ensure better utilisation and value.

4.1.4 Spot purchasing

DAT partnerships are encouraged to retain the flexibility to commission on an individual basis for the small number of clients who have specific assessed needs that are not catered for by providers who are routinely referred to or contracted with, therefore preserving the capability to offer a reasonable degree of client choice. Where spot purchasing is undertaken, care needs to be taken to ensure the same standards of care pathways and aftercare planning are applied.

In addition, if a DAT partnership has a provider where it routinely place clients (for example a local inpatient unit), then at the times when this unit is full, provision should be considered from elsewhere (resources allowing) if the alternative would be an unacceptably long waiting time.

4.1.5 Preferred providers

For both block and spot contracts, commissioners need to build strong relationships with providers, working towards the development of a preferred provider model. For non-statutory providers, full cost recovery needs to be part of the commissioning relationship as outlined in the Compact's Funding and Procurement (Compact, 2005) code of good practice for the voluntary sector.

4.1.6 Registering under the Care Standards Act (2000) with the Commission for Social Care Inspection

Residential service provision offering care and accommodation on the same site will be covered by the Commission for Social Care Inspection (CSCI) – see Annex 4. If the service provision offered is detoxification, then the provider may also be registered as a care home with nursing by CSCI. Alternatively, if the provider is an independent hospital then the provider will be registered with the Healthcare Commission (HCC). Inspection reports can be obtained from the CSCI or HCC websites. These reports provide information on the quality of certain aspects of care, such as care planning and assessments, as well as premises and staffing.

When commissioning service provision, commissioners should check whether the provider should be registered with either CSCI or the HCC. If this is not the case, then DAT partnerships should ensure that some form of external scrutiny is in place, such as the Quality Assessment Framework (QAF) produced by Supporting People, or an independent accreditation scheme.

There is no statutory impediment to purchasing placements from non-registered services using either community care or pooled treatment budgets.

4.1.7 Local care pathways

Clear and agreed care pathways, in line with the Care Planning Practice Guide (NTA, 2006a), will be most effective if they are widely publicised across each partnership system. Consideration should be given to publishing eligibility and suitability criteria for all forms of Tier 4 treatment should

be available and users and other service providers made aware of their existence and meaning. Please see Annex 5 for further guidance on eligibility criteria for RR.

4.1.8 Early interventions

There is limited research evidence to inform the assessment of need for the provision of early, direct entry to inpatient treatment or to residential rehabilitation for some clients, who have not met the commonly used criterion of previous failure with Tier 3 provision aimed at supporting their abstinence. It is possible some clients in crisis and some younger drug misusers earlier in their drug-using careers may benefit from relatively early access to Tier 4 provision. Local commissioners and partnerships may usefully consider such potential need for Tier 4 within their local expert groups and commissioning partnership discussions concerning eligibility, and may usefully monitor outcomes (including use of TOP) in any local examples of such cases.

4.1.9 Tier 4 service provision or interventions for people in the criminal justice system

A large proportion of service users of RR are offenders, under statutory supervision by the National Probation Service. In planning appropriate commissioning for this group, the following issues may need to be considered:

- Referrers from the criminal justice system should refer to local commissioning guidance (where available) as to the preferred providers for the partnership, sub-region or region
- It is good practice to plan any transfer of an offender to a residential rehabilitation centre in another DAT or probation area. The receiving probation area needs to be involved in any decisions being made about the potential placement, prior to the offender residing in the residential rehabilitation centre
- Commissioners need to ensure that residential rehabilitation centres have protocols with their local probation areas to inform them of any referrals they have from other probation areas
- Where places are commissioned in RR for offenders under an order with a drug rehabilitation requirement (DRR), the relevant regularity and rigour of testing necessary needs to be specified.

4.1.10 Client preparation for admission

Preparation for admission to RR and IP is essential to ensure more effective outcomes can be achieved through a comprehensive assessment process, which will demonstrate if RR or IP treatment is likely to be the most effective treatment intervention to meet the client's needs. It is important to ensure that – in order to meet the local authority community care Fair Access to Care Services (FACS) eligibility criteria – clients are suitable and are "treatment ready". Partnership assessment frameworks should be able to demonstrate this (please see Annex 5).

4.1.11 Inter-partnership care pathways

The referral of individuals to Tier 4 service provision often requires them to travel out of their normal DAT partnership areas of residence. Where this is the case, careful planning will ensure that there is good communication between the partnership of residence and partnership of treatment. This communication is especially important at discharge, whether planned or unplanned and should always follow agreement of confidentiality boundaries with clients as part of their care plans. Individuals who elect to stay on in the partnership area of Tier 4 treatment (and did not originate there) following discharge can place a burden on local public services and community drug agencies, especially when their arrival is not planned. Depending upon their discharge plan, support should be offered to clients who originate from outside the area to provide them with the means of transport to return to their home areas where appropriate. This may be especially important in the case of an unplanned discharge and best practice would be, for example (and where practicable), to accompany clients to bus or train stations and see them onto their transport.

If clients elect to remain in the DAT partnership area of treatment, then it is good practice to inform the referring DAT partnership, maintaining communication as appropriate between the clients' DAT partnerships of origin and their new DAT partnership area of residence. The new method of allocating pooled treatment budget (PTB) monies to partnerships based on need rather than formula will go some way to assisting the small number of DAT areas who (due to large concentrations of Tier 4 agencies within their boundaries) import a significant number of drug users into their community treatment system year on year.

Note: Some clients who are subject to statutory supervision by HM Probation Service may have requirements that constrain changes of address and so consultation with the supervising offender manager may be needed in these cases.

4.1.12 Treatment duration

One of the key distinguishing factors between residential rehabilitation services is their intended programme length. There is no one answer to the question of what the appropriate programme length would be for any one individual but the relevant factors have been discussed previously in Models of Residential Rehabilitation (NTA, 2006d) and the Commissioning Tier 4 Drug Treatment (NTA, 2006b). In brief:

- Research shows that treatment episodes of 12 weeks and longer are more likely to be effective. (When commissioning, it is necessary to look at the provider's actual average length of stay rather than suggested treatment duration to establish likely length of episodes.)
- Longer episodes of treatment may work well for those with particular co-existing factors such as complex social problems and mental health problems
- Shorter episodes of treatment (such as 6–8 weeks) are likely to provide either an enhanced detoxification or a stabilisation programme. In such cases onward referral to further treatment may be necessary
- The efficacy of a treatment programme is also dependent on the amount of weekly client contact time and providers may be expected to declare this, with timetables showing how time is spent.

4.1.13 Commissioning adequate aftercare

In Models of Care aftercare was identified as an important element in maintaining and enhancing progress made in Tier 4 provision. Consequently they should be given due consideration in any DAT partnership's needs assessment. Those services providing accommodation-based aftercare are often funded through Supporting People monies. To supplement the Supporting People QAF, commissioners may also consider voluntary accreditation schemes – for example, the one provided by the European Association for the Treatment of Addiction (EATA).

Service users leaving residential rehabilitation need aftercare to support consolidation of their treatment gain. The nature and location of this aftercare means that it needs to be planned in good time prior to leaving residential service provision as part of normal ongoing care-planned treatment and as part of the discharge care-planning. When departure from residential rehabilitation is planned, the needs of the individual needs to be considered by the residential treatment provider, in discussion with the purchasing or referring care manager, and any onward referrals made (in accordance with confidentiality boundaries previously agreed with the client as part of their care plans). It is good practice to establish early liaison with the potential aftercare providers in the destination area of residence (whether this is back to their home areas or not) at the earliest opportunity..

Users of residential rehabilitation not returning to their home areas also require aftercare upon leaving. When departure is planned the needs of the individual should be considered by the treatment provider, in discussion with the purchasing or referring care manager, and onward referrals made.

It is reasonable to expect that residential rehabilitation providers will have sources for local accommodation, available to people settling in the vicinity of the service.

Many providers offer a follow-up or secondary service to extend the treatment episode and aid reintegration. Such services are offered under a variety of different funding mechanisms. Purchasing and referring care managers, when considering the benefit to the client in continuing placements in “secondary” residential service provision, should consider the likelihood that this will enhance treatment. In particular, the availability of education, training and employment services and any evidence the provider can provide of the enhanced likelihood of prolonged benefit should be considered.

Detoxification-only interventions should be followed by a period of psychosocial treatment, the nature of which should be established and provision secured, where possible, prior to the period of detoxification commencing.

In planning aftercare for service users leaving residential rehabilitation and detoxification facilities safeguards and plans to deal with heightened overdose risk may well be required.

4.1.14 Products of the commissioning process

There are different ways that DAT partnerships can go about commissioning Tier 4 interventions. Some partnerships are currently developing arrangements to jointly commission Tier 4 interventions, in the manner of long-established practices found elsewhere in the public sector where high-cost and low-volume service provision are required. However, such clustering (see Annex 6 for more details) is just one model and the key consideration is that partnerships find their own best ways of achieving the following objectives.

- Agreeing eligibility and suitability criteria for all Tier 4 service provision
- Developing of robust integrated care pathways
- Agreeing common assessment frameworks and tools to ensure consistency in referrals
- Ensuring providers comply with their requirements to report to NDTMS (including Treatment Outcome Profile data as appropriate)
- Challenging poor waiting times and using techniques such as process mapping to identify blockages throughout the system
- Identifying preferred providers (for both block contracts and spot purchasing)
- Negotiating on cost, where an increased volume of treatment provision due to clustering arrangements is achieved
- Providing a rigorous and informed assessment of provider performance and quality
- Exploring the possibilities for including Tier 4 outcomes in local area agreements (LAAs)
- Liaising with user groups and representatives
- Agreeing common performance measures for any provider where clustering arrangements are in place
- Continual assessing of service performance and suitability for clients – leading to recommissioning if necessary
- Developing an adequate local evidence base on what works within Tier 4 treatment journeys and for what type of clients
- Liaising closely with local CSCI registration and inspection teams to help the process become more meaningful for the particular requirements of residential drug treatment provision.
- Making use of information about unit costs of Tier 4 service provision (where available) to ensure delivery of value for money.

Key staff such as community care managers should where practicable be involved in the ongoing assessment of need for their local DAT partnerships and ideally should be operating within a framework for which they have helped to shape and define eligibility criteria.

Consideration needs to be given to the training needs for Tier 3 staff in order to ensure that there is an adequate understanding among referrers as to the choice of service provision on offer and what sort of client need are catered for. Additionally, some staff may be put off from making referrals because they perceive the referral and funding processes to be complex and time consuming. Efforts need to be made by DAT partnerships to ensure that staff understand the local system and feel confident in embarking on the referral process.

4.1.15 The use of funding panels

Some areas elect to use panels of local experts to make decisions as to whether individuals should be funded for admission to residential rehabilitation. The use of such a model is entirely legitimate, providing it operates within the overarching DAT partnership's strategic framework and that the regularity of when it meets does not build unnecessary waits in to the system. The NTA's guidance on waiting times (NTA, 2007d) is clear that the waiting time for all interventions should be recorded from the time that clients agree with their care co-ordinators that the referral process starts. Therefore, a panel that only meets once every three weeks can automatically put a blockage into the system.

5 Involving users and carers in the commissioning and delivery of Tier 4 or service provision or interventions

5.1 Listening to clients

Although there are individuals who require long-term treatment maintenance within a community setting, a majority of clients report an aspiration to become drug-free and move out of the treatment system altogether. Naturally, such exits need to be managed and realistic, as unplanned discharge from a treatment that requires detoxification prior to entry carries with it the attendant risk of overdose if the client then subsequently relapses (Smyth et al, 2005). However, the fact remains that many clients do report abstinence as their ultimate goal resulting from involvement in treatment.

There are various ways to listen to what the client wants, including looking at research evidence of what clients want, and what is shown to be effective, as well as talking to local user forums. Another important factor in client consultation is good-quality care planning. If this is being done properly, clients will be equal partners in their treatment and will be fully consulted on what they want to get out of it.

5.1.1 Differences of opinion

Practitioner assessment of a client's current readiness for inpatient or residential assisted withdrawal may be quite at odds with the view expressed by the client. In the case of such discrepancy, it will be important for practitioners positively to acknowledge the client's view and to be explicit about the rationale for their professional judgement and about any changes a client might make that would enable a referral appropriately to be made. Clearly, such cases may also benefit from multidisciplinary discussion.

5.1.2 Involving clients in the commissioning and planning of treatment

Many joint commissioning groups now have user and carer representation. The active involvement of users and carers and serious consideration of their recommendations is very important. For example, users and carers commonly report their requirement for respite models of Tier 4 provision, but commissioners have often been slow to commission this type of treatment, or providers to offer it. The problem underlying such a recommendation may first require further exploration for alternative less expensive, or more easily available, solutions. However, further consideration may also identify the real need for such provision.

5.1.3 Setting up feedback loops

It is considered good practice to have a formal mechanism for obtaining clients' views (where practicable) of their Tier 4 treatment experience. This can provide valuable information (when set in context) as to the quality and suitability of the providers involved. For instance, some DAT partnerships have asked service users to view a residential service and comment prior to making a purchasing or commissioning decision.

5.2 Listening to carers

There is sound evidence that the support and involvement of carers (Smith and Myers, 2004) can improve the prognosis of clients' treatment journeys. Coupled with this, carers will often have their own needs that need to be factored into the partnership's commissioning priorities.

As with users, carer representation needs to be present at all stages of the commissioning cycle. Carers have a right to an assessment by their local authority on their ability to provide and continue to provide care for the user under the Carers (Recognition and Services) Act 1995. In addition, there is a new scheme called New Deal for Carers, outlined in *Our Health, Our Care, Our Say*

(Department of Health, 2006), which aims to provide funding for emergency respite and may be suitable for this client group in some instances.

5.2.1 Keeping carers informed of client progress

Following the agreement of confidentiality boundaries with clients upon their admission, services should seek to keep carers informed of their progress in treatment – including being informed and involved in the formulation of a discharge and aftercare plan (within which they may play a key role). As part of this process, it may need to be made clear to carers that users may never return to their home areas.

Wherever appropriate, carers should be informed of an unplanned discharge in order to prepare them for clients coming to their homes and asking to stay. In addition, carers may need to be informed of the risks associated with overdose and the signs and symptoms to look for. The period after discharge from a stay in residential rehabilitation is a high risk time for fatal overdose due to reduced tolerance.

5.3 Supporting users and carers in the commissioning process

Although many DAT partnerships have users and carers sitting on their commissioning groups, it is vital that appropriate training and support is put in place to ensure that the user and carer representatives are enabled to make a full contribution to the process.

6 Elements usually considered as good practice requirements of residential rehabilitation providers

The models and types of services providing Tier 4 treatment vary enormously, far more than under Tiers 2 or 3. While a certain degree of diversity of desirable, the scope of choice can serve to confuse commissioners and service users alike. Sections 6.1–6.9 list components of effective provision that are normally expected of providers.

6.1 Structured programmes

Structured programmes are characterised as:

- Evidence based for the desired outcome, for example detoxification and abstinence (this can be drawn from a combination of the research literature and in-house evaluations of outcomes: see section seven for further details)
- In line with written guidance (at least to the point where there are set protocols for groups and other interventions)
- Adaptable to user requirements (for example, able to deal with differing lengths of treatment)
- Requiring a substantial commitment of time and effort from the service user.

6.2 Integrated care pathways and onward referral

Integrated pathways should include the following elements:

- Providers to co-operate with peers in ensuring that there are clear admission and reception arrangements, and set handovers to care managers and other providers at the end of interventions
- Continuing care and treatment needs are always considered and referrals made, including when clients abscond or leave early
- Exit plans and aftercare options are defined at admission
- Reviews are regular and involve external professionals (for example referring care managers)
- Relapse prevention and safety training are included as part of programmes
- Clear reporting mechanisms for dealing with absconders are in place (for their protection).

6.3 Engagement with national monitoring programmes and statutory information sharing protocols

- Providers should submit NDTMS data in line with published national requirements (NTA, 2007a). Monthly reports of Tier 4 activity reported to NDTMS – broken down by DAT area and provider – can now be found on the National Drug Evidence Centre’s website.¹
- Providing TOP data in accordance with published national requirements (Marsden *et al.*, 2007)
- Submitting to scrutiny in relation to unit costs

¹ <http://www.ndtms.net/Tier4ReportsPublic.aspx> . Tier 4 activity reports are available on the secure website www.NDTMS.net for access and to request a password please contact Ndtmsqueries@nta-nhs.org.uk

- Participating in national benchmarking exercises (such as joint NTA and Healthcare Commission Improvement Reviews).
- If the provider is registered on the BEDVACS system, commissioners and service users should be able to assume that all data submitted is accurate and up-to-date

Local protocols should be in place between providers and the Probation Service regarding the sharing of information (including probation national standard compliance and enforcement issues).

6.4 External monitoring and validation where possible

Examples include:

- CSCI registration
- HCC registration
- Supporting People monitoring
- Up to date EATA accreditation
- Drug Strategy and DAT partnership accreditation schemes.

6.5 Contracting issues

Providers will need to show that:

- Treatment regimes and lengths are flexible for individuals and subject to specification by commissioner (if block contracted)
- Monitoring information can be provided, including retention, length of stay, contact and activity time, progress according to specified benchmarks.

6.6 Transparency regarding value for money

In order to judge value for money the following information can be made available:

- Costs and prices available based on NTA templates (when available)
- Willingness to provide full accounts from service block purchased (for which a quid pro quo is full cost recovery)
- Prices linked to NHS tariffs where appropriate.

6.7 Discharge arrangements that protect service users

Pre-agreed arrangements can include:

- Providers should, as a matter of good practice, notify the DAT partnership and treatment system of residence and treatment² (if they are different) as soon as arrangements are agreed with the client for planned discharge or when an unplanned discharge has occurred (in line with confidentiality boundaries agreed as part of the individual's care plan)
- Continual contact with referring care managers
- Discharge to a known destination
- Availability of resettlement and second stage housing
- Relapse prevention and safety training as part of programme
- Reporting for dealing with absconders (for their protection).

² DAT of residence is the area where the client is normally resident of. DAT of treatment is the area in which the Tier 4 service provision is located.

6.8 Attention and care given to diversity of customers

For example:

- If the service provision is multi-gender then consideration needs to be given to the provision of secure, discrete areas for the accommodation of women
- Provision needs to be made for the needs of those with physical, sensory or learning disabilities
- Providers need to be able to meet dietary requirements for different religions
- Programmes need to be constructed to allow for the needs of gay, lesbian, bisexual and transgender clients
- Policy needs to be clear regarding the use of psychotropic medication for mental health problems.

6.9 User and carer involvement

Providers of Tier 4 service provision need also endeavour to fully consult with users (and carers) when designing and planning their services. For example, a number of non-statutory Tier 4 providers now have user representation on their boards.

7 The evidence base for Tier 4 service provision

7.1 Previous reviews of research

In 2006, the NTA published Models of Residential Rehabilitation (2006d) and Commissioning Tier 4 Drug Treatment (2006b). Both of these publications contain a review of the available research on the effectiveness of residential rehabilitation.

It is fair to say that, while the UK evidence base is patchy at best, there is substantial evidence from elsewhere, especially the USA, to show that residential treatment is effective. Some research also indicates support for the therapeutic community and 12-Step (Minnesota) methods.

7.2 What does the published research indicate regarding Tier 4 drug treatment service provision in the UK?

- a Inpatient assisted withdrawal is more effective in a residential setting. There is clear evidence that patients undergoing assisted withdrawal in inpatient units have significantly better outcomes than those who withdraw in the community, with one study reporting a four-fold benefit for inpatient service provision in the number of clients achieving abstinence (Gossop *et al.*, 1986). Reported rates of abstinence 24 hours after treatment range from 17–28 per cent in outpatient settings compared to 80–85 per cent in inpatient settings (Dawe *et al.*, 1991; Gossop and Strang, 1991).
- b Inpatient assisted withdrawal is more effective in a specialist setting. However, this assertion is based on a single randomised trial with a total sample of 186 heroin addicts who were randomised either to a specialist setting or to a general psychiatric ward. The completion rate for detoxification was more than twice as high in the specialist setting than in the general psychiatry ward (42 vs. 18 per cent). Admissions to the specialist unit were also more likely to be drug-free at the seven-month follow-up point.
- c Clients undergoing an assisted withdrawal who have follow-up treatment tend to have better outcomes: Ghodse *et al.* (2002) attempted to assess outcomes in patients who either completed inpatient assisted withdrawal or left early and found no differences in drug use outcomes. However, they did find that significantly better outcomes were reported for those clients who had gone on to spend at least six weeks in a RR service provision than those who did not.
- d Inpatient treatment is not as expensive as it first seems: Gossop and Strang (2000) calculated that the cost of inpatient detox was 24 times as costly as community assisted withdrawal. However, when adjustments were made for treatment outcomes, the real cost of a ten-day inpatient detoxification was actually slightly cheaper than for a community detoxification.

7.3 Recent research

Recently, Meier and Best (2006) surveyed residential rehabilitation providers in the UK and found that the average client completion rate across 57 providers was 48 per cent. This finding is replicated when examining the latest available NDTMS data. When subsequent analysis was conducted, the predictors of better outcomes were:

- Lower counsellor caseloads
- Fewer beds
- Single rooms
- Shorter scheduled duration of treatment
- Higher fees per client

- "Balanced" programmes of activity.

8 Summary of the findings from a national assessment of Tier 4 need

From the NTA's National Tier 4 Needs Assessment (Best *et al.*, 2005):

- Demand for inpatient assisted withdrawal considerably outstrips provision and many clients perceive it as being protected and inaccessible
- The role of Tier 4 in providing respite for carers has been markedly understated
- There is marked inconsistency across DAT areas and regions in the commitment of commissioners to Tier 4 service provision, reflected in huge variability in the proportion of treatment budgets spent on residential treatment
- There is no clear rationale for measuring need for residential treatment, with many services mistrustful of client choice in this area
- There is poor provision of residential service provision (both IP and RR) for particular vulnerable groups (such as those with co-morbid mental health problems, those with co-existing alcohol problems, clients with dependent children, stimulant users, young dependent drug users, and clients with disabilities and learning difficulties).
- There is a received wisdom amongst certain commissioners and providers of Tier 4 that it is desirable for clients to receive IP service provision locally yet travel miles away from their homes for RR. There is no clear evidence base as to whether this is true and therefore each client's circumstances should be judged individually as to what package of care would best suit their needs and circumstances.
- There is no clear evidence base around matching of clients to types of residential provision or particular Tier 4 treatment journeys (Audit Commission, 2004).

In the review of inpatient service provision, Day *et al.* (2005) reported that there were estimated to be 10,771 admissions for inpatient drug treatment in 2003/04, with provision falling into three broad categories – specialist settings, generalist wards (not only psychiatric but also general medical wards) and residential rehab service provision that offered "front-end" detoxification service provision. The evidence base regarding the latter two categories was virtually non-existent in the UK. However, even within the specialist providers, there was considerable variability in what was offered to clients – in terms of length of stay, medications used, levels of medical input, clinical and therapeutic programmes and links to other treatment provision. The authors concluded that there were generally poor links between inpatient providers and between these providers and the providers of rehab and aftercare service provision.

9 Considering the evidence in commissioning

It is important to be realistic about what can be achieved by Tier 4 drug treatment provision, with NTORS suggesting that around half of those admitted to residential treatment service provision no longer use any opiates two years later. This is not always recognised or acknowledged in the treatment field. Because of the perceived cost, users feel that they have to jump through all kinds of hoops just to find out what is out there, and that actually gaining admission is a major achievement (Best *et al.*, 2005).

To the extent that NTORS can be relied upon ten years later, almost half of those who attend residential service provision achieve opiate abstinence that is enduring. There is also some evidence to suggest what is required to tilt the odds towards a successful outcome:

- Specialist input
- Residential settings
- Detoxification followed by at least six weeks of rehab
- Continuity of care (and care planning)
- Lower counsellor caseloads
- Accommodation that affords privacy
- Balanced therapeutic treatment programmes.

As the NICE draft psychosocial guidelines (National Institute for Health and Clinical Excellence, 2007) acknowledge, more research into this area is urgently required, along with careful analysis of TOP data which will start to give comprehensive data on the outcomes of individuals whose treatment journeys include a Tier 4 component.

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Annex 1: Definitions of inpatient assessment, stabilisation and assisted withdrawal service provision

Models of Care for the Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006c) identifies inpatient drug treatment as follows:

Inpatient drug treatment interventions usually involve short episodes of hospital based (or equivalent) drug and alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for treatment such as:

- Medically supervised assessment
- Stabilisation on substitute medication
- Detoxification and assisted withdrawal from illegal and substitute drugs and alcohol in the case of polydependence
- Specialist inpatient treatments for stimulant users
- Emergency medical care for drug users in drug-related crisis.

The multidisciplinary team can include psychologists, nurses, pharmacists, occupational therapists, social workers, and other activity and support staff.

Inpatient drug treatment should be provided within a care plan with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

Care planned inpatient treatment programmes may also include a range of additional provisions such as:

- Preparing the client for admission to inpatient treatment (if this is not carried out by a suitably competent community worker as part of the agreed care plan leading to admission)
- Psychosocial interventions, including relapse prevention work
- Interventions to tackle excessive levels of drinking
- Appropriate tests and immunisation (if appropriate), for hepatitis B and C, and HIV
- Other harm reduction interventions
- Educational work
- Physical and mental health screening
- Linking inpatient treatment to post-discharge care – this may involve preparation for referral to residential rehabilitation or community treatment, aftercare or other support required by the client.

Inpatient drug treatment is an important intervention for enabling adequate assessment of complex needs and supporting progression to abstinence.

It is very important to have effective discharge care planning, and to ensure appropriate referrals to mainstream medical services (for example liver clinics and psychiatric services) or social and community services (such as housing, legal advice and social services), as well as harm reduction and relapse prevention advice as required.

Annex 2: Definition of residential rehabilitation service provision for substance misusers

Models of Care: Update 2006 (NTA, 2006c) identifies residential rehabilitation as follows:

Drug residential rehabilitation consists of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence-orientated drug interventions within the context of residential accommodation.

Residential rehabilitation programmes should include care planning with regular keyworking with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

There are a wide range of types of residential rehabilitation service provision, which include:

- Drug and alcohol residential rehabilitation service provision whose programmes suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-Step programmes and faith-based (usually Christian) programmes.
- Residential drug and alcohol crisis intervention services (in larger urban areas).
- Inpatient detoxification directly attached to residential rehabilitation programmes.
- Residential treatment programmes for specific client groups (for example drug-using pregnant women, drug users with liver problems, and drug users with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug services (Tier 3 or 4 – depending on local arrangements) and other specialist inpatient units.
- “Second stage” rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive keywork and a range of drug and non-drug-related support
- Other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different local site(s).

Residential rehabilitation programmes normally combine a mixture of group work, psychosocial interventions and practical and vocational activities. These components are also used in specialist residential programmes for particular client groups (for example parent and child programmes).

Clients usually begin residential rehabilitation after completing inpatient detoxification. Sometimes the detoxification will take place on the same site as the rehabilitation programme, to enhance continuity of care. Prior to starting the rehabilitation programme, clients should be supported by keyworkers (or other substance misuse professional) to prepare for admission, so as to minimise disengagement and maximise benefit, but there may also be preparation input from the rehabilitation service.

Annex 3: Definitions of aftercare

Aftercare, as described in Models of Care, is a package of support that is planned with clients to support them when they leave structured treatment. The aim of aftercare is to sustain treatment gains and further develop community reintegration. Aftercare may include drug-related interventions such as open access relapse prevention or harm reduction. It may also include non-drug-related support such as housing, access to education, and generic health and social care. It is important to note that aftercare is not necessarily what clients receive after leaving Tier 4 treatment or prison, as they may still have an active care plan, involving community interventions. Only once the client's care plan is complete do they enter planned aftercare.

During a period of care-planned treatment, clients will receive a range of interventions to address their drug and alcohol-using behaviour and interventions to target non-substance use domains of functioning (such as housing and family support). Some of these interventions will come to an end when the care plan comes to an end, but some may need to continue.

As long as clients have an active care plan they are considered to be in treatment. When their care plans with treatment providers come to an end, they may continue to receive a range of services that they were receiving as part of the care plan, and in this context, these will be deemed to be aftercare. These will include drug- and non-drug-related support.

There is a need to ensure the client has access to support pathways (for housing and training, for example). If links to all appropriate support services are not already in place during a client's care-planned treatment, drug treatment agencies should assist clients to make these links before their treatment comes to an end. The keyworker or service will need to work closely with local agencies providing aftercare and support services to enable all necessary support to be in place in time for the client leaving treatment.

During the completion or exit phase of treatment, an aftercare plan will typically be drawn up by the keyworker and agreed with the client, based on assessment of ongoing support needs, and informed where possible by related professionals (such as housing and CJIT workers).

The aftercare plan should include measures that cover possible relapse and ensure swift access back to treatment if required. The aftercare plan must be passed from the drug treatment agency to the agencies responsible for delivering the aftercare, and key staff in this agency should endeavour to ensure that the plan is implemented and clients receive what is outlined in the aftercare plan.

Drug-related support could include open-access relapse prevention, mutual support groups (for example, AA and NA or equivalent user-led groups), and advice and harm reduction support. In addition, a range of open-access and low-threshold interventions should be available to provide specific interventions to people who have completed treatment, but who may want or need to have occasional non-care-planned support.

Non-drug-related support can cover a range of issues such as access to housing, supported accommodation, relationship support, education and training, support to gain employment, and parenting and childcare responsibilities. In addition, women's services, peer mentor programmes and other social and activity groups can form elements of non-drug-related support.

Annex 4: Extract from Models of Care: Update 2006

National minimum standards for care homes for younger adults

The national minimum standards for care homes for younger adults were issued under the Care Standards Act 2000. The Commission for Social Care Inspection (CSCI) currently has the remit to inspect and regulate individual establishments, agencies and institutions for which registration as care homes is required. The standards specifically apply to care homes for people with alcohol or substance misuse problems and cover choice of home, individual needs and choices, lifestyle, personal and healthcare support, concerns, complaints and protection, environment, staffing, and conduct and management of the home. They also specify the national occupational standards for staff. In order to meet registration criteria, staff and managers are required to have relevant TOPSS NVQ qualifications, or demonstrate they are working towards them.

Annex 5: Eligibility criteria for access to public funding for residential rehabilitation service provision

Introduction

- 1 Unlike most community drug and alcohol treatment service provision that are free at the point of delivery, residential rehabilitation service provision can be very expensive and most people cannot afford to fund their stay without financial assistance
- 2 Residential rehabilitation placements may require either a significant or partial contribution from local authority community care budgets
- 3 This will depend on how funding and budget holding decisions are taken locally. (for example, actual pooled budget including CC funding and adult pooled treatment budget, community care funding only).

Fair Access to Care Services guidance and eligibility criteria (FACS)

- 1 In 2002, the Department of Health issued guidance on fair access to care services (DH, 2002) to councils with social services responsibilities on how they could achieve fair access to care services through reviewing and revising their eligibility criteria for adult social care
- 2 This guidance required every local authority to work within a national eligibility framework, based on four levels of risk to independence
- 3 These levels are low, moderate, substantial and critical. An assessment or review is required to establish the level of risk (needs assessment)
- 4 Each local authority must set its threshold for services based on their resources. Any person meeting that threshold can expect to have their eligible needs met, in order to address the risks that have been identified
- 5 Because of the different resource positions of local authorities, the guidance does not require them to reach similar decisions on eligibility, or to provide similar service provision, to people in similar needs
- 6 FACS guidance requires that only one decision is taken after assessment – are the needs that the person presents with eligible for support or not?

Eligibility criteria and thresholds

- 1 Local authorities across the country have developed their criteria based on this guidance to determine if an adult has social care needs that are eligible for services arranged or provided by social services departments. The fair access to care services criteria cover all adult services such as services for older people, people with learning disabilities as well as people with drug and alcohol problems. They have set their criteria taking into account their available resources and target their services at those in greatest need.
- 2 They will not fund care for people who, after assessment, fall below a fixed threshold.
- 3 Community care budget holders determine eligibility for access to services and community care funding. For many people access to Tier 4 service provision will not be funded if individual needs fall below the critical or substantial threshold based on the four levels of risk.

Assessment of need

- 1 FACS guidance requires that only one decision is taken after assessment – are the needs that the person presents with eligible for support or not?

- 2 The FACS guidance and the assessment process are inextricably linked in determining eligibility for services.
- 3 Good assessment systems will take full account of the different ways in which alcohol and drug misusers present for services, their different characteristics and their particular needs
- 4 There is good evidence base for the efficacy of Tier 4 interventions in delivering long-term positive outcomes (including abstinence) for clients who are properly prepared and assessed prior to admission, remain in treatment and receive appropriate aftercare. Models of Care and the Treatment Effectiveness strategy both emphasise the key role of properly resourced and delivered Tier 4 service provision in the treatment journeys of services users identifying abstinence as a care plan goal
- 5 The guidance Commissioning Tier 4 Drug Treatment (NTA, 2006b) suggests that Tier 4 treatment should be purchased and commissioned as part of an integrated local treatment system, which is strategically commissioned across all treatment tiers and in line with national guidelines
- 6 Tier 4 service provision should be commissioned in the context of an agreed integrated care pathway for clients. These integrated care pathways should be commissioned with clear routes into inpatient service provision, which seamlessly lead to residential rehabilitation (if required) followed by a community-based substance misuse support package and aftercare.

Indicators for suitability for residential rehabilitation

- 1 It is essential to ensure that in order to meet the FACS eligibility criteria and for the treatment intervention to be successful and meet the outcomes required by the service user particularly abstinence, service users are suitable and are "treatment ready".
- 2 Service users likely to be most suitable and also meet the FACS eligibility criteria for rehabilitative programmes are those who:
 - Are motivated to achieve lasting abstinence
 - Have and or have had medium-to-high dependence on drugs
 - Have substance misuse patterns of long duration and a chaotic nature
 - Have high levels of need in terms of health and social care issues
 - Lack family and community support networks
 - Have found it difficult to achieve abstinence in the community
 - Need to receive treatment away from their usual drug and alcohol-orientated community or family environment
 - Are required as part of a court-ordered drug rehabilitation requirement
 - Are unable to sustain in all or most aspects of work and education and learning causing a major loss of independence
- 3 All clients considered for rehabilitative programmes will have received a comprehensive drug and alcohol misuse assessment that indicates a need for residential treatment. Assessment processes should take account of all of the above indicators.
- 4 Before or as part of the assessment process it is best practice to record indicators for suitability to ascertain whether service users are treatment ready and are likely to meet local authority and DAT partnership eligibility criteria
- 5 Most service users would meet the substantial if not the critical threshold using the suitability criteria indicated above

- 6 It is essential that partnerships develop integrated care pathways for Tier 4 service provision and that all workers are aware of the accessibility and availability of Tier 4 service provision and the assessment and eligibility framework.

Annex 6: Regional or cluster commissioning structures

The concept of a number of DAT partnerships within an individual region clustering together to jointly commission Tier 4 service provision is already being put into place in a number of areas across the country and has longstanding precedents in other parts of the public sector requiring high-cost and low-volume service provision.

The fundamental principle is that a number of DAT partnership areas delegate day-to-day responsibility for commissioning of Tier 4 service provision to a lead area and perhaps even a named individual who could act as a single point of contact (SPoC) for anyone concerned with the commissioning and provision of Tier 4 service provision. The role of the SPoC could be to achieve consistency in areas outlined under section three of this guidance.

Partnerships would need to agree their total Tier 4 spending for the year prior to entering into a clustering agreement. There is no intention that money from each member of the cluster would be pooled in the sense that there would be no ring fence for each individual partnership's budget; rather that the commissioning of this service provision is done consistently and more efficiently.

A cluster would be free to choose which types of provision they may want to jointly commission through the SPoC (such as inpatient service provision but not residential rehabilitation).

Consideration would need to be given as to which partnership and agency would host the SPoC and any partnership entering into such an arrangement would need to clear on the parameters within which the SPoC could operate on a day-to-day basis on their behalf.