

Acknowledgements

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Executive summary

Background

Although the evidence base is weak, particularly in the UK, there is evidence that, where drug abstinence is the goal, detoxification is more likely to be successful in residential settings. Additionally, when outcomes include economic analyses, detoxification undertaken in residential settings has been shown to be at least as cost-effective as community detoxification. Similarly, there is some evidence, from the National Treatment Outcome Research Study (NTORS) and from international research, supporting the effectiveness of residential rehabilitation (RR) treatment. Furthermore, there is UK evidence that where residential detoxification is supported by follow-up rehabilitation in a residential setting, the outcome is significantly enhanced. However, the evidence base on what is currently available in England is limited, as is detailed analysis on what process issues are associated with successful outcomes in residential treatment settings.

Rationale and method

The needs assessment attempted to build on existing knowledge of provision in England by reviewing existing needs work in the addiction

field, to assist in the development of a method and to provide an overview of localised perspectives on Tier 4 need. The project also attempted to complement the review of inpatient detoxification (IPD) conducted by the University of Birmingham and aims to parallel the work of this project by mapping service uptake and client profile in residential rehabilitation services.

Residential rehabilitation survey

Sixty-five of 105 residential rehabilitation services (61 per cent) replied to the survey, reporting an occupancy rate of 74 per cent – lower than the 84 per cent occupancy rate reported in BEDVACS (an online list of bed vacancies operated on behalf of the NTA). The key needs identified related to improving the skills and training of the staff, increasing the number of beds to meet demand and improving the flexibility of the services to meet both the needs of particular populations, such as women with children and Black and minority ethnic (BME) groups, and clients with complex treatment needs, as well as users of a range of different drugs.

Availability of residential rehabilitation

The 48 agencies who returned the questionnaire had each treated 58 drug patients in the previous year (during 2003/04). If this estimate is extrapolated up to the 105 RR services identified, this would suggest that a total of 6,090 RR places were made available for drug users in 2003/04. As with the IPD estimates, this is markedly higher than the NDTMS return of 4,531 for the same period.

Inpatient detoxification survey

Thirty-one per cent of IPD provision takes place in specialist detoxification units, 50 per cent in "non-dedicated" services on psychiatric or acute medical wards and 19 per cent in residential rehabilitation services that offered "front end" drug detoxification. Sixty-three per cent of consultants in IPDs felt that the numbers of IPD beds were either "inadequate" or "totally inadequate" and more than half that the range of services offered was either "inadequate" or "totally inadequate". There was marked regional variation in the level of provision and in the range of services offered, while the routes into and from IPD treatment were extremely variable.

Availability of inpatient detoxification

Day *et al* (2004) estimated there were 356 drug detoxification beds available in specialist units

and 103 beds available with some form of detoxification facility in general psychiatry or medical wards. They calculated this would provide a total level of provision of 10,711 drug IPD admissions in 2003/04, across the three types of provision. However, only 6,829 of these are estimated to take place in specialist units, with a further 2,077 provided in general psychiatry wards and 1,805 in residential rehabilitation settings. This is significantly higher than the NDTMS assessment of 5,557 IPD episodes in 2003/04, suggesting some reporting limitations at the time.

Survey of the 149 commissioners

Forty-five per cent of reporting DAT commissioners replied to the survey, suggesting that an average of 51 individuals attempted to access IPD services each year. Although around half of the responding commissioners were reasonably satisfied with what they currently offered, the average number of additional places that would benefit the DAT was estimated as 76 for IPD provision. The rate of completion for RR was also estimated at around 40 per cent of those who were perceived to need this form of treatment, but the perceived need for additional RR resource was estimated to be much lower at 33 places per DAT (compared to the 76 additional places reported IPD). However, the proportion of women estimated as needing additional resource for RR (40 per cent) was higher than that reported for IPD in each DAT area (23 per cent). Based on the estimates of additional need in the participating DATs, there would need to be an increase of 161 per cent in the provision of IPD for 2004/5 and of 95 per cent in the level of RR provision. This equates to a perceived demand of 22,492 places in Tier 4 services for 2004/5 among DAT commissioners, if the estimates are extrapolated nationally.

Applying the Rush alcohol model to current levels of service uptake

2003/04: In contrast, applying a model developed in the context of Canadian alcohol services (Rush, 1990) which assumes that 15 per cent of the treatment population will require specialist inpatient treatment, then the overall requirement for Tier 4 would have been 18,885 for 2003/04, 12,865 in IPD or other short-term residential treatment and 6,020 for RR.

2004/05: Based on a projected number in structured Tier 3 or Tier 4 treatment of 135,000, the level of short-term residential provision needed would be 13,500 and the level of long-term residential treatment would be 6,750 – a required inpatient provision of 20,250.

2007/08: Assuming that the overall targets for structured treatment are met, there will be 163,900 drug users in structured Tier 3 or Tier 4 treatment and the requirement for IPD will be 16,390 and 8,195 for RR. This would mean that the overall level of provision for 2007/08 would be 24,585.

Using a systems approach for estimating need

In contrast, if the survey data is used, the need for expansion to fulfil the requirements to the end of the drug strategy is slightly different. There will have to be provision for 16,390 episodes of IPD – on the basis of total existing provision, this will involve an increase from 8,634 (the number of IPD episodes which take place in either specialist or residential units), requiring an additional 7,756 places to be available by 2007/08 to meet the ten per cent treatment target. This will involve an increase of 90 per cent of the IPD provision.

Region	PDU estimate	NDTMS total treatment group	Total no. in Tier 4 according to NDTMS	Estimated need for IPD in 07/08 ¹	Estimated need for RR in 07/08 ²
East Midlands	25972 (9.0%)	9132 (7.1%)	239	1164	582
East of England	21846 (7.6%)	9050 (7.0%)	715	1147	574
London	45501 (15.8%)	22165 (17.2%)	2979	2819	1410
North East	15769 (5.5%)	6948 (5.4%)	590	885	443
North West	48715 (16.9%)	27630 (21.5%)	2207	3524	1762
South East	39943 (13.9%)	11659 (9.1%)	976	1492	745
South West	27580 (9.6%)	12964 (10.1%)	1147	1655	827
West Midlands	28700 (10.0%)	12986 (10.1%)	877	1655	827
Yorkshire & Humber	33650 (11.7%)	16111 (12.5%)	338	2049	1025
National total:	287676 (100%)	128645 (100%)	10068	16390	8195

Table 1: NDTMS estimates of 2003/04 provision and demand-based predictions of 2007/08 need

Regional variations

In making these assessments, it is important to recognise that there are huge variations in levels of provision across regions. These would be reflected in future projections of likely need, as shown in table 1.

While there are data limitations in these interpretations, as already stated for NTORS, the variations in representation are indicative of the variability that currently exists as projected to future treatment targets, which will require significant increases in the overall level of provision. The overall increase of 144 per cent to the end of the drug strategy (calculated by the NDTMS baseline against the Public Sector Agreement (PSA) treatment target) masks the increased provision of 809 per cent that will be required in the Yorkshire and Humber region or the 631 per cent increase that may be needed in the East Midlands region, if current NDTMS returns are accurate.

Data management problems are an issue. The NTA will strive to address these over the remaining years of the drug strategy. Nonetheless, the data generated gives a clear picture of underprovision of Tier 4 services, with marked regional variations making the need particularly acute in some areas. This overall capacity issue is compounded by problems around continuity of care – as identified in the Audit Commission (2004) report – consistency of provision across services, including marked limitations in onwards referral and aftercare and additional problems experienced by many of those who are rendered most vulnerable by co-

morbid mental health problems, their family situation and polydrug use patterns.

1 Based on a service utilisation ratio of ten per cent of the Public Sector Agreement drug treatment target

2 Based on a service utilisation ratio of five per cent of the Public Sector Agreement drug treatment target

Recommendations

1. Effective funding to ensure continuity of care from IPD to RR, without gaps in provision between completing detoxification and starting rehabilitation. The limitations in overall levels of service provision need to be addressed by increases in capacity, particularly within the IPD provision, and this should be linked to appropriate follow-up care planning
2. All Tier 4 treatment should be linked to effective care planning and review, which allows for adequate aftercare provision and supported housing if required. Aftercare is essential if the benefit from IPD and RR is to be maximised
3. There needs to be appropriate shared assessment instruments across services, to ensure that potential admissions are fairly and consistently assessed for suitability for Tier 4 treatment
4. There needs to be a programmatic commitment to joint training and consultation between Tier 3 and Tier 4 services, to ensure adequate client placement and effective throughcare, case management and care co-ordination
5. However, this overall planning must be co-ordinated by the NTA, involving community care and health services at a national level to ensure that national provision (particularly for RR) is compatible with demand. This will require increases in bed provision of at least 35–90 per cent between 2004 and 2008, to enable effective treatment to be delivered that is consistent with the PSA targets for treatment
6. It is essential that there is increased information to clients and carers about the treatment options available within Tier 4 (including information on treatment philosophy)
7. There needs to be a commitment to increased user and carer involvement in needs analysis, as a core part of service development and funding
8. There is inadequate provision of specialist Tier 4 services for women, particularly those with dependent children, and a paucity of services for pregnant drug users, especially for IPD
9. Significant expansion in the provision of IPD facilities is required in local areas, to meet overall demand and more complex needs, including mental health provision and needs of disabled users and family groups
10. The shortfall in IPD should not be redressed using beds in general psychiatry wards, other than as a treatment of last resort. There is clear evidence that IPD is less likely to be completed and that users find it less satisfactory. Earlier dropout from this form of provision will serve as a hindrance for services attempting to meet the new three-month treatment effectiveness targets, aiming to ensure adequate continuity of care
11. Better Tier 4 provision for young people is required, possibly based on a needs assessment equivalent to this one. For this reason, it is recommended that a Tier 4 needs assessment be conducted for young people under the age of 21
12. There is a need for improved research into Tier 4 outcomes, including assessments of modality and length of stay for RR
13. Far better local and national information on Tier 4 service provision is needed, throughput and outcomes, supplemented by adequate local evaluations of Tier 4 services
14. There should be development of a common evaluation and monitoring system that enables local assessment of the effectiveness of commissioning of treatment, its underlying principles and its impact on overall drug problems (in relation to prevalence) and problem profiles (defined in terms of incidence), would enhance recommendation 13.

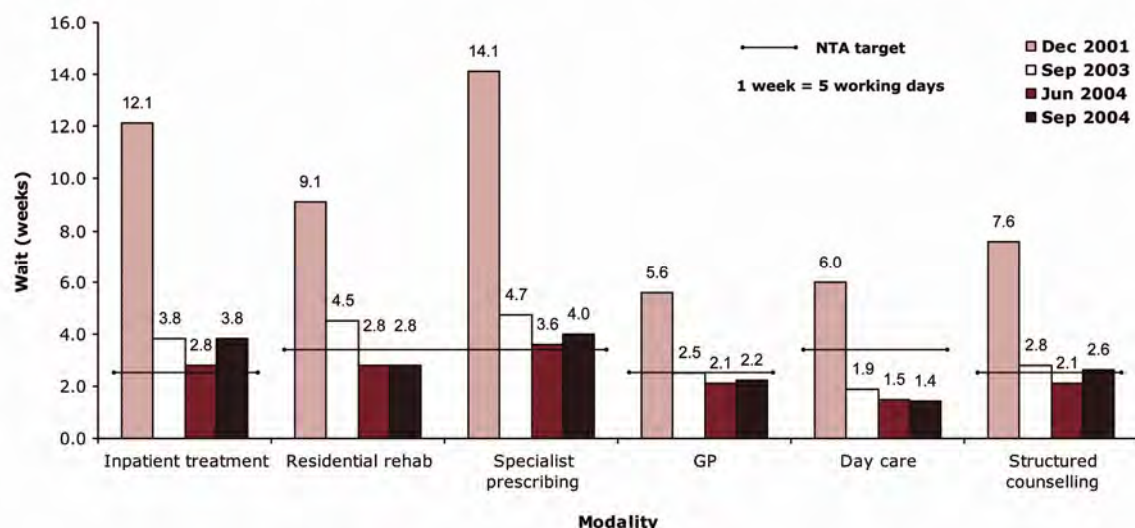


Figure 2: National average waiting times across treatment modalities during the NTA's existence

Background

The needs assessment is part of an NTA programme of work assessing the provision of Tier 4 drug treatment in England. According to *Models of care for the treatment of adult drug misusers* (NTA, 2002), Tier 4 services are “aimed at individuals with a high level of presenting need”, and consist of “abstinence-oriented programmes, detoxification services or services which stabilise clients” (*Models of care*, p19). *Models of care* divides Tier 4 services into two classes – Tier 4a services that are classed as “residential drug and alcohol misuse specific services” and Tier 4b services, described as “highly specialist non-substance misuse specific services”. Tier 4a is usually divided between IPD and RR services, although it should be noted that both types of treatment provision can be provided within the same physical treatment setting.

This project arose out of concerns about the accessibility and capacity of Tier 4 services, particularly the fact that this treatment modality failed to meet the April 2003 waiting time target and appeared unlikely to meet the April 2004 target (despite reductions in waiting times for other treatment modalities). The NTA's Public Sector Agreement (PSA) target – requiring the doubling of the numbers in treatment between 1998 and 2008 – added urgency to the need to obtain more accurate national information on service uptake and future need, while the treatment effectiveness agenda provides a clear mandate for improved provision of services oriented towards establishing safe and effective drug abstinence, and assisting in the maintenance of that state. This form of

treatment is relatively expensive for each treatment episode: therefore it is important to consider carefully how to develop this sector most effectively, and ensure that it contributes to the overall profile of service provision and makes an effective contribution to the treatment journey.

The objective of this study was to address the above concerns by matching supply with demand and setting out the national need for Tier 4 drug treatment – for both IPD and RR. This study focuses on Tier 4a services for drug users in RR and IPD.

Introduction

Tier 4 provision: what works?

Much of the recent evidence about Tier 4 services comes from the National Treatment Outcome Research Study (NTORS, Gossop *et al*, 1998), a prospective and naturalistic investigation of treatment outcomes for entrants into community and residential drug services. The study included 23 residential services – eight IPD services and 15 RR facilities – with significant improvements across health and crime domains reported for the majority of patients attending this type of treatment. One year after treatment initiation, half of the Tier 4 clients were abstinent from heroin and substantial mean reductions in injecting, sharing of injecting equipment, heavy drinking and crime were also reported. There was, however, a critical minimum period for demonstrating these improvements, with those patients attending for a minimum of 28 days exhibiting the most enduring benefits across

Domain	Community setting (Tier 3)		Residential setting (Tier 4: IPD and RR)	
	Intake	Year one	Intake	Year one
Crime	62%	40%	64%	39%
Psychiatric health problems (self reported suicidal tendency)	26%	17%	31%	20%
Non-fatal overdose	11%	5%	22%	7%

Table 2: NTORS year one outcomes for crime, psychological health and non-fatal overdose³

problem domains for IPD. The equivalent figure for RR was 90 days.

Table 2 indicates that clients experienced improvements in psychological health levels, risk of overdose and criminal behaviour in both community and residential settings. Improvements for clients treated in Tier 4 are particularly marked, partially as a result of slightly higher levels of problem behaviour at intake. Four hundred and eight clients (or 40 per cent) of the NTORS follow-up sample had Tier 4 services as their index treatment (i.e. the treatment received by clients during the research).

Inpatient detoxification

Based on the existing evidence, Mattick and Hall (1996) have argued that detoxification is unlikely to be effective if treated as a standalone abstinence-oriented treatment. However, appropriate detoxification and rehabilitation, they argue, can be highly effective in achieving a number of positive treatment outcomes, including changes in drug use, reductions in crime and reductions in risk behaviours associated with the spread of blood-borne viruses (Keen *et al*, 2000).

There is a limited but consistent evidence base showing significantly greater rates of abstinence among patients experiencing detoxification in inpatient units rather than community settings (Gossop *et al*, 1989). In a separate study, Gossop and colleagues (1986) reported that inpatient treatment was four times more effective than community treatment in assisting clients to complete the detoxification process.

The percentage of outpatients who achieve abstinence from opiates, for even as little as 24 hours after treatment, has been measured as between 17 and 28 per cent (Gossop *et al*, 1986; Dawe *et al*, 1991), compared to equivalent abstinence rates for IPD of between 80 and 85 per cent (Gossop *et al*, 1986; Gossop and Strang, 1991). In a US review of treatment effectiveness Lipton and Maranda (1983) reported abstinence rates of 50–77 per cent were reported for IPD, compared to rates of around 20 per cent for outpatient

detoxification. Therefore, IPD can be seen as a more reliable method of achieving a drug-free state than detoxification in the community.

Gossop and Strang (2000) calculated that the cost of IPD was 24 times greater than for community detoxification. However, when adjustments were made for outcomes, the costs of a ten-day inpatient programme were marginally lower than those for an outpatient detoxification programme. However, these effects are mediated by setting. Strang *et al* (1997) and Ghodse *et al* (1997) have demonstrated that drug users achieve better outcomes when treated in specialist drug units than in general psychiatry wards, and also maintained abstinence over longer periods of time. Gossop (2004) has argued that the benefits of IPD include not only greater probability of abstinence, but also that it can provide the first phase of an integrated treatment programme, in which patients are returned to outpatient treatment abstinent and ready for relapse prevention treatments. However, it is important to conclude that the evidence base, particularly that conducted in a UK setting, is extremely limited.

Residential rehabilitation

Although there is an equally limited evidence base for RR, both UK (Georgakis, 1995) and US (DeLeon *et al*, 1982, Simpson, 1997) studies have shown positive psychosocial benefits after RR treatment, with the US evidence indicating that more positive outcomes are associated with treatment episodes of at least three months. For one particular category of RR provision, the therapeutic community, DeLeon *et al* (1979) have shown that attenders experience sustained and enduring reductions in substance use after attendance at therapeutic communities.

Ghodse *et al* (2002) examined outcomes in a cohort of patients who either completed or

³ Percentages indicate the proportion of clients who reported conducted crimes or experienced psychiatric health problems or non-fatal overdoses

failed to complete inpatient treatment. While there was no clear relationship between treatment completion and drug use at any of the follow-up points, significantly better outcomes were reported for those who completed detoxification and then went on to spend at least six weeks in some form of residential rehabilitation service, suggesting the importance of the continuity of residential treatment.

The evidence from the international literature is more extensive and frequently based on larger sample sizes. In an analysis of data collected for the Treatment Outcome Prospective Study (TOPS), Condelli and Hubbard (1994) found that one type of RR – therapeutic communities – was effective in reducing drug use, unemployment and criminal behaviour. As with previous studies, a clear relationship was reported between time in treatment and the positive outcomes achieved.

In terms of cost-effectiveness, Flynn *et al* (1999), using the results from the Drug Abuse Treatment Outcome Study (DATOS), examined 3,000 residential clients and 202 attending drug-free outpatient services. They found the overall benefit of combined residential treatment and aftercare ranged from a factor of 1.68 to a factor of 2.73, and from 1.36 to 3.26 for outpatient drug-free treatment. This study again emphasises the “added value” of continuity of care.

However, this benefit may be mediated by duration of stay. Retention in treatment would appear to be particularly important – an NTORS paper (Gossop *et al*, 1999) used 28 days as the crucial retention period for IPD and 90 days for RR. It was found that those who stayed for the critical time reported 40 per cent less acquisitive crime, 47 per cent less drug selling and 55 per cent less heroin use at the two-year outcome point, compared to those who dropped out before these critical times.

Policy foundations

Drug action teams (DATs) and their strategic partners are required to conduct population-based needs assessments as part of the

treatment planning process. Materials designed to assist the exercise include the Commissioning Standards (SMAS, 2000)⁴ and the Home Office Drug Treatment Demand Model.⁵

The effectiveness of this process was challenged by the report *Changing Habits* (Audit Commission 2002) which found considerable room for improvement:

“... local needs were identified from one-off studies, based largely on information about national prevalence and trends, rather than local data, and were often out of date. Attempts to identify latent demand or consider future trends in drug misuse and their impact upon demand for services were rare.”
(Page 58)

Methods for measuring needs

Despite the requirement for effective needs assessment models, there is limited literature on how to measure the need for substance misuse treatment.

One method of attempting to measure need based on demand is the prevalence:service utilisation ratio (PSUR) method, although this has been applied primarily to alcohol populations. According to this model (Phillips *et al*, 2004), around ten per cent of the problem drinking population are estimated to present to treatment services annually. Ten per cent of this group (or one per cent of the overall problem drinking population) will require inpatient treatment. The problem with such a model is that it does not account for the levels of harm that may be addressed by targeting interventions at populations who may require, but have not actively sought, treatment. In other words, it is based on actual rather than latent demand for treatment.

One alternative would be a “systems approach” as it measures treatment by combining existing information about treatment demands (obtained through measures such as waiting lists and number of referrals relative to number of admissions) with “system” indicators of harms accrued in particular areas, that may be indicative of unmet need in the areas under investigation. The systems approach is based on what should be available and is not solely reliant on what currently exists – based on estimating the size of the population in need and working out what proportion should be treated in a given year, mapped against the configuration of available services.

4 The Commissioning Standards (Substance Abuse Advisory Service 2000) recommend analysing information about substances used, target populations, health and psychological problems, social functioning and life context; mapping services available to each target group, estimating and identifying unmet needs

5 This models the flow of PDUs in the community and criminal justice system which enables DATs to match resources to demand alongside the annual DAT/CDRP planning round

However, the efficacy of each of these approaches is contingent on available data and resources. As a basic minimum, Ford and Luckey (1983) identified four key stages for assessing need:

1. Determine the geographic size of the population to be served
2. Estimate the number of problem users within each population group
3. Estimate the number of individuals from stage 2 that should be treated in a given year (defined as the demand population)
4. Estimate the number of individuals from step 3 that will require some service from each component of the treatment system.

Using this approach for assessing alcohol-related need, Rush (1990) used existing data from a number of Canadian provinces to extrapolate that 15 per cent of problem drinkers in Canada can be considered to be the treatment “target” group in any given year. This estimate was based on alcohol-related mortality data, national population survey data on drinking and population data on average consumption levels. The problem group in this area was calculated as 7.2 per cent of the population over the age of 15, or 8.6 per cent of the drinking population.

The model developed, based on a cohort of 10,000 problem drinkers, assumes that 1,500 (15 per cent) will request treatment in a given year, of whom two-thirds will make it as far as assessment. From this group, around 8.6 per cent of the original cohort will be referred to specialist services (867 individuals). Of this group, 55 per cent will be referred to outpatient services, 30 per cent to day treatment, ten per cent to short-term residential treatment and five per cent to long-term residential treatment. However, around 20 per cent will drop out from each treatment modality before completing these treatments. Furthermore, around four per cent of the original group will be directly referred to services (i.e. after emergency or criminal justice attendance), resulting in a total of around 950 clients (or 9.5 per cent of the original 10,000) who will actually access specialist services, with the majority of these most appropriately dealt with in outpatient settings. The key point is that routes to and through treatment are not necessarily consistent or ubiquitous, and are inevitably interlinked.

However, this method of assessing need is limited by the viability of available data sources, both to measure the demand for existing treatment services and for testing the formulas

that attempt to assess the level of unmet need that does not take the form of explicit demand.

Systems-based approaches

Systematic assessment of drugs-related treatment need has been conducted infrequently in England and much of the evidence for good practice derives from the alcohol field. In relation to alcohol services, Godfrey, Hardman and McKenna (1993) suggested the use of multiple sources for attempting to assess the “in-need” population, using three broad data types to assess overall need:

1. Direct measures of substance consumption
2. Extrapolation from existing survey work
3. Using substance-related problems as indicators.

Godfrey *et al* included statistics on drinking and driving, drunkenness offences, alcohol-related mortality and morbidity, sickness absence and accidents at work. The level of need identified is then mapped against current level of treatment provision (through treatment mapping) and an assessment of current services, capacity and gaps (measured by interviewing key informants or surveys of services).

The next stage was to predict the likely flow of clients through the treatment system in a given time period. The authors then required a resource assessment to map the likely costs of fulfilling identified need and point out that the model will require a number of cycles before it can be fully implemented. Therefore, the match between demand, need and supply can only be addressed adequately over a period of calibration and refining of the original estimates. This stage is important as it helps adjust and refine the model to fit with empirical evidence and users’ experiences and will be shaped by available capacity, actual numbers of people who seek treatment, and treatment effectiveness.

Local needs assessments and reports

However, extrapolating data from alcohol to drugs can be dangerous, given the limitations of research in this area. Therefore, one of the key approaches considered was to examine the existing locally-conducted, drugs-focused needs assessments, in order to identify useful data and innovative methods. This approach was extremely disappointing, yielding relatively little systematic work. The reports that could be identified (and were the most up to date) are summarised in Annex 1. The dominant theme

highlighted in these reports is the need for additional provision of local residential treatment facilities, particularly for IPD. This overall need is supplemented by concerns about the limitations of provision for particular vulnerable populations, especially women and those with co-morbid mental health problems.

What are we measuring need for?

The project attempted to utilise national epidemiological data as a means of creating a framework for assessing existing demand and linking this to estimates of overall problem drug using populations. This allows us to assess the proportions of problem users inside and beyond current levels of treatment provision, at both national and regional levels.

The rationale is then based on testing two models – the first to assess the proportion of those within the treatment process who are likely to be in need of Tier 4. This will require an assessment of the entry points to Tier 4 and the flow of patients who make it through each of these phases. It is critical to bear in mind that the success of Tiers 2 and 3 in attracting and managing clients will shape the demand for Tier 4 (and client perceptions about efficacy), both in terms of its capacity to retain clients and in terms of the likelihood of successful drug problem resolution without inpatient treatment. This is, in essence, a demand-based model assessing aspects of the current treatment provision to assess likely demand and projected uptake of IPD and RR, among those already in contact with treatment services.

The second task is calculating need that is not based on demand – this will constitute either “missed opportunities” or identified harms at a population level that are indicative of failures of penetration by the treatment system into “vulnerable” use populations. For this objective, secondary markers (primarily those defined as Tier 4b service need plus mortality and criminal justice information sources), such as liver failure and drug-related deaths, are available as possible indicators in two forms. First, they are informative in absolute terms – the higher the levels of each of these factors, the less successful the treatment system (including Tier 4) has been.

However, there is a second sense in which this information can be used – by working out the proportion of those who experience a targeted harm who have contact with treatment services (both generally and specifically for Tier 4), it is possible to calculate the penetration of the treatment system into the “at risk” population for any given harm.

In model A, there is an assumption that relatively few individuals who experience the index harms have had treatment contact, suggesting a low level of treatment penetration to problem drug users (PDUs) at risk for key indicators of outcomes. Therefore, if the overall rates of drug-related liver disease, drug-related mortality, uptake of needle exchanges and so on are generally high (e.g. above national norms) and the penetration rate is low (i.e. few who experience these outcomes are in contact with treatment services or have had recent contact with services), then we can infer that there is a high level of need given that treatment is not reaching those who are vulnerable to adverse outcomes.

In contrast, model B outlines the opposite scenario in which a high proportion of those who experience index harms are already in contact with treatment services. In this scenario, there are two possible inferences. If the total rate of the harm is low (e.g. below national or regional averages or the trend is downwards), then penetration is high and the provision of treatment may well be having a protective effect. In contrast, if in model B, the overall rate of the harm is high, yet penetration is also high, then we can assume that treatment is not influencing the likelihood of the harm as we would hope it would, from a public health perspective, i.e. treatment is ineffective if measured against this harm. Once an overall rate of risk and penetration is calculated for individual outcomes, then it will be possible to examine the differential risks for particular groups of PDUs – women, BME groups and young drug users, for example. However, in the current analysis, the first unit for within group comparison will be by region.

This method emphasises the distinction between what is assessed in the treatment cohort and the PDU group not in contact with any form of treatment – with the outcome indicators used allowing an estimate of domain-specific unmet need, to identify treatment impact in relation to that need and treatment penetration associated with vulnerable populations across risk domains.

However, this will provide only half of the model outlined by Godfrey, Hardman and McKenna (1993), so it is essential to provide some assessment of treatment availability and perceived utility, to assess the likely flow of patients through IPD and RR in any given period. Six sources of information have either been mined or developed to enable this part of the equation to be calculated:

1. A survey of providers of RR

2. A survey of providers of IPD (based on the IPD review undertaken by the University of Birmingham)
3. A survey of joint commissioning managers
4. An analysis of recently conducted local needs analysis or other secondary indicators that provide information about local needs (such as local treatment plans)
5. Key informant group discussions
6. Assessment of perceptions of users and carers.

These information sources are then combined with research evidence on effectiveness and the epidemiological systems analysis, to permit quantifiable estimations of need mediated by local factors, where the appropriate information is available.

Findings

Residential rehabilitation questionnaires

Method

The primary data collection method was a survey of 105 services providing residential rehabilitation treatment, identified through the NTA residential directory. Six of the listed services, which only provided supported accommodation, were excluded. The questionnaire was partly based on the schedule used in the IPD survey conducted by the University of Birmingham, amended to cover RR services. The questionnaire was piloted with the advisory group developed for the study and with one RR provider. The survey was posted out to each of the RR units identified, targeting the service manager, and was followed up by telephone contact to encourage completion. In total, 65 of the 105 identified RR units (61 per cent) returned the questionnaire – an excellent response rate given the requested one-month completion and return period.

Details of 78 participating agencies

Fifty-one (80 per cent) of those agencies that replied were registered as care homes with a regional distribution as shown in table 3.

Exactly half the agencies did not have a specific breakdown of beds for drugs and alcohol, with those who did being equally likely to have more beds for drugs than for alcohol, with only a small number of services having specific beds for Drug Interventions Programme (formerly the Criminal Justice Intervention Programme (CJIP)) clients. The mean occupancy rate was reported as 74 per cent (lower than the 84 per cent reported on BEDVACS for April 2005), although it is notable that there was a wide range of occupancy rates in the previous year, ranging from 40 per cent to 98 per cent. Participating units reported that they averaged a total of 58 drug admissions per year, although again the range was extremely large, with between one and 211 drug users admitted in 2003/04.

Source of clients

The majority of agencies reported that clients were referred from a range of sources with the most common being community care teams (n=61), self-referrals by the clients (n=58), Tier 2 services (n=57), primary care (n=55) and Tier 3 services (n=53). Other referral sources included family, employers, prison, probation, detoxification services, CJIP/DIP teams, former patients and private insurance companies.

Available services

Twenty-two of the services (34 per cent) provided a front-end detoxification service, with the majority of these beds not specific to either drugs or alcohol. The vast majority of services providing detoxification facilities (17 of the 20 that answered the question) also started rehabilitative treatment at the same time. The service managers generally felt that the length of time available for detoxification was satisfactory (in 17 of 22 cases, 77 per cent), and most expressed satisfaction with the level of staffing available. Only 18 of the services offered a pre-care scheme (with only 14 of these offering it to all clients) and several of the respondents were unaware of how pre-admission schemes operated. Twenty-five per cent of the participating agencies reported they were not satisfied with the current arrangements for aftercare, with a further seven agencies not answering this question.

Specific populations

Forty-nine of the services (75 per cent) offered provision to both men and women, with twelve offering services to men only and two services providing RR facilities only to women. Of services that catered for female clients, 16 (32 per cent) reported that they offered services for pregnant drug users, but only one service offered a facility for mothers with children under the age of six months and one for mothers with children over the age of six months. In total, 21 agencies (32 per cent) reported that they would like to provide other services for pregnant drug users and drug-using mothers, but were unable to do so.

Although a high proportion of agencies attempted to address the needs of BME clients, with 45 (83 per cent) offering culturally sensitive menu options and 44 (68 per cent) offering support for religious needs or cultural beliefs,

Region	Frequency	Percent
East Midlands	2	3.2
London	11	17.4
Wales	2	3.2
East of England	5	7.9
North East	2	3.2
North West	11	17.4
South East	13	20.6
South West	13	20.6
West Midlands	3	4.8
Yorkshire and Humber	1	1.7
Total	63	100

Table 3: Distribution of responding RR services by region

the uptake of services among BME groups was low, with services reporting between zero and six BME clients attending in 2003/2004, averaging at around three per service. Nonetheless, 73 per cent of the RR services completing the questionnaire expressed satisfaction with the services offered to BME groups.

Identifying and addressing unmet need

Fifty-nine RR services (90 per cent) reported that they measure the extent to which they address the needs of their clients, with several using multiple methods. The most common method was informal feedback from house meetings and client forums, as well as questionnaires and evaluations. Furthermore, external evaluation took the form of inspections by the Commission for Social Care and "Supporting People" review visits. However, a much smaller proportion (42 per cent) reported that they attempted to assess the extent to which the needs of carers or family members are accounted for. Again, it is important to note that the needs monitoring was primarily carried out among those who had been successful in accessing the service.

Only 33 services (50 per cent) reported that they had taken part in any research, evaluation or audit projects in the five years prior to the questionnaire, but less than ten of these agencies were able to provide copies of the reports. This low level of systematic data collection may have hampered the effective measurement and monitoring of needs.

Overview and conclusions

Funding

Funding was a dominating theme, predominately related to issues that would enable RR providers to better accommodate the needs of clients. More funding would:

- Enable more staff training and increased staffing levels. It would also help services become more effective generally. Others commented that, if more funds were available, they could set up or expand their offer of outreach and/or supported accommodation. One provider felt that:

"Many service users will struggle to live independently in the weeks, months and indeed some cases years after residential treatment. There is an acute shortage of quality supported housing for this very vulnerable group."

- The need for continuity of care and the importance of support beyond the completion of the treatment programme was reflected in the claim that there was a clear need for:

"Funding for outreach work to cover the first six weeks when residents move into their own accommodation, generally considered to be the most stressful time when they are most at risk and in need of support – time when most residents likely to relapse."

- Many of the providers felt that more funding was needed to increase the number of beds for clients and to improve the quality of accommodation.
- The need for flexible funding was raised by providers (and also picked up by the users and carers). It was argued that more funding would allow clients to progress at a natural pace and not hasten completion due to funding limitations. Also there is a perception of a bias in funding, e.g. "sometimes funders will only pay for unsuitable rehab regimes that do not fit with individual need". However, the need for improved service funding and flexibility was supplemented by concerns about the adequacy of the referral and case management process. One service provider argued for:

"Better understanding by statutory services and community care assessors of the needs of clients requiring RR so that they are directed to the service that will best meet their needs."

- The individuality of clients and their specific needs were also discussed by providers. Several respondents reported that residential treatment must be seen as part of an integrated plan that includes detoxification, throughcare and appropriate accommodation after programme completion. This is reflected in the view that:

"In terms of a systematic approach to integrated care plans (ICPs), we are looking at the whole continuum of care, of which residential rehab is part of that delivery, culminating in re-integration, community re-

enforcement, aftercare and relapse prevention.”

- The importance of appropriate case management and referral to ensure that clients were arriving at RR in an appropriate state were reflected in the view that:

“More importance should be placed on transition and aftercare, clients access Tiers 1, 2 and 3 before rehab.”

Treatment for specific populations

The questionnaire also assessed availability of provision for specific groups (such as the disabled, young people, pregnant women, parents with children and stimulant users), who are often perceived to be less well served by drug services. The inadequacy of current arrangements was highlighted by this study.

“We recently opened a female unit with accommodation provided for children. However it is inadequate and long term we would like to offer a full-time parent and child unit.”

At present, most RR services provide support groups e.g. gender-specific support groups, parenting groups and parenting support, while some also offer family therapy and counselling for children of clients, although the provision of such services is inconsistent.

The study did identify two services (in the south-east and north of England) which either plan to, or currently provide “tag-on” services for substance misusing pregnant women provided in an annex to the main building. However, such facilities are not consistently provided and the security of provision does not accord with the identified level of need.

Service providers (and also commissioners) referred to the need to improve provision for BME groups, physically disabled drug users and dual diagnosis clients. However, this was not identified as such a high order issue as problems with funding, throughcare, meeting individual needs and addressing the needs of people with children.

Identified needs	No. of agencies
Additional resources / more beds	12
Staff training / improved specialist input	12
Need for a dedicated specialist unit	11
Wider range of services / therapeutic inputs	10
Better joint working / improved communication	9
More adequate aftercare provision	6
Better physical environment	5
Improved access / reduced waiting times	4
Protection or ring-fencing of drug treatment beds	4
Alternative or complementary therapies	2

Table 4: Additional needs expressed by lead clinicians completing IPD questionnaire

Inpatient detoxification review

The survey of existing inpatient detoxification services for drugs was carried out by a research team from the University of Birmingham (and a full report on this project is available separately through the NTA). The report is based on a self-completion questionnaire sent to the lead clinician in each service, assessing bed capacity, retention, treatment process and issues around additional services and throughcare required. In total, 129 IPD providers were identified of whom 91 responded to the postal questionnaire (a response rate of 71 per cent). An estimation of the total bed capacity in both specialist and general units is given in the overall needs analysis section.

The survey estimated that 31 per cent of IPD provision takes place in specialist detoxification units, 50 per cent in “non-dedicated” services on psychiatric or acute medical wards and 19 per cent in residential rehabilitation services that offered “front end” drug detoxification. The current mean waiting time for admission at participating IPD services was 23 days.

Lead clinician’s identification of unmet needs

An open-ended question was presented to allow the lead clinician to list areas of identified needs that were not currently addressed.

The authors concluded that, particularly for health providers, staff shortages have had an adverse impact on the level of service offered. Similarly, they reported that only around two-thirds of the IPD services required patients to have an aftercare plan in place prior to admission. Non-specialist units were also markedly less likely (12 per cent) than specialist providers (23 per cent) to discharge patients into residential rehabilitation services. Seventy-nine per cent of the specialist services and 75 per cent of the RR services were satisfied with current arrangements for aftercare, compared with 92 per cent of the non-dedicated IPD providers.

When asked about their perceptions of the overall quality of inpatient provision in their locality, the majority of clinicians expressed dissatisfaction. Sixty-three per cent of respondents felt that the numbers of IPD beds were either “inadequate” or “totally inadequate” and more than half felt the range of services offered were either “inadequate” or “totally inadequate”. Similarly, 48 per cent of respondents felt that local inpatient services were unsuitable.

Although there were clear themes around the levels of staffing and support, the quality of the facilities and the range of treatment options that could be provided, very few of the services identified only one need, with most of the issues addressed relating to complex, multifaceted needs as outlined in the response that:

“As we are an open acute ward for mental health, it is wholly unsuitable for detox. We offer support but nothing as structured as a rehab placement. We have drug and alcohol issues on the ward and, due to sectioned [patients] and dual diagnosis, abuse does not lead to discharge, so there is little help with preventing access to substances. Also, we are 20 miles from a general hospital, so we can’t deal with high physical risks.”

The concerns expressed about lack of suitable facilities and appropriate treatment options and clinical skills were particularly marked from services which provided IPD on general psychiatric wards, but limitations in provision were not restricted to such services. The complex problems of addressing patient needs are also evident in the assertion that the service needs:

“To have single rooms for all patients with en suite facilities. To increase recruitment and retention of staff. To have certain members of the ward staff to have specialist knowledge in dealing with patients with drug and alcohol dependence problems. To reduce waiting times for patients to be seen by the psychiatrist.”

Finally, it is important to note that the needs of any given service cannot be considered in isolation and that the availability of other treatment options, as well as patient preferences, will shape the effectiveness of provision:

“We need ring-fenced beds, preferably off the psychiatric ward. Also 24-hour nursing provision. Alcohol detoxifications in the local general hospital are even more inadequate, so beds are not sought. The reason for the very low rate of opiate detoxification is (1) community

	Male	Female
Number of referrals for IPD	36	15
Number of assessments for IPD	33	16
Number of admissions for IPD	22	10
Number completions for IPD	15	7

Table 5: Rates of referral, assessment, admission and completion for inpatient detoxification by DATs completing the survey⁶

detoxification is a default allocation plus reliance on maintenance and reduction of substitutes and (2) the inpatient unit is very unpopular with opiate users."

Overview/conclusion

Despite recent reductions in waiting times, the level of provision is not perceived to be adequate, either in terms of volume or in terms of quality, by a significant proportion of the lead clinicians at IPD services who took part in the review conducted by the University of Birmingham. The main concerns that need to be addressed are:

1. Lack of specialist skills on units providing detoxification in general psychiatric settings and too much reliance on treatment in general psychiatry and medical units
2. Insufficient specialist beds and insufficient ring-fencing of those that do exist
3. Limited range of treatment options and treatment settings that are not conducive to positive treatment outcomes, and lack of flexibility in existing provision
4. Failures of throughcare and aftercare and inadequate communications with referrers and treatment planners
5. Inconsistencies in user involvement, measurement of user satisfaction and any form of engagement with families and carers.

Questionnaires to joint commissioning managers

Of the 149 drug action teams in England, 67 (45 per cent) completed questionnaires on the perceived need for Tier 4 provision, with a further three questionnaires received too late for analysis, but whose comments have been incorporated within the qualitative analysis. The purpose of the survey was to ascertain how services are commissioned and funded, and how performance is managed and evaluated. It also sought to obtain details of relevant health planning and policy documents, and monitor

how need is being assessed for residential drug treatment.

Referral and funding routes

Tier 3 prescribing services constituted the main access route to IPD for drug users, with 27 per cent of commissioners reporting that all of their IPD clients came through this route and a further 22 per cent reporting that the majority of their IPD clients came from Tier 3. However, 34 per cent of commissioners reported that criminal justice interventions were a major source for IPD for drugs. For RR services, the referral routes are broadly similar. Ten per cent of commissioners reported that all of their RR referrals come from Tier 3, 22 per cent that most come from this source and 27 per cent that some come from Tier 3, suggesting that a substantial proportion of RR caseloads come directly from community treatment, rather than via specialist IPD services. In contrast to IPD, social care also plays a significant role in referrals to RR, with ten per cent of commissioners reporting that all, 15 per cent most and 24 per cent some of their referrals come from this source.

With regard to IPD funding, the main funding sources are the primary care trust (PCT) and the pooled treatment budget (PTB), with the main additional source of funding being CJIP/DIP. The same three sources are prominent in the funding of RR, although PTBs play a more dominant role, along with community care funding.

Demand for and uptake of IPD services

Table 5 outlines the reported average levels of demand, uptake and completion of IPD treatment by DAT in 2004.

On average, just under half (43 per cent) of those referred for inpatient detoxification were successfully detoxed in 2003/4, while around three-quarters of those referred are admitted to IPD facilities. This suggests that a significant number of referred clients are falling through the net either because their needs are being met elsewhere or because of system failures that mean a significant proportion of those identified as viable candidates are failing to receive this form of treatment.

However, the variability in numbers reported at each stage (the range of referrals for drug IPD treatment was between zero and 260),

⁶ The number of commissioners who completed this item was variable and ranged from 50 for number of admissions to 38 for number of assessments, suggesting data availability is imperfect in this area

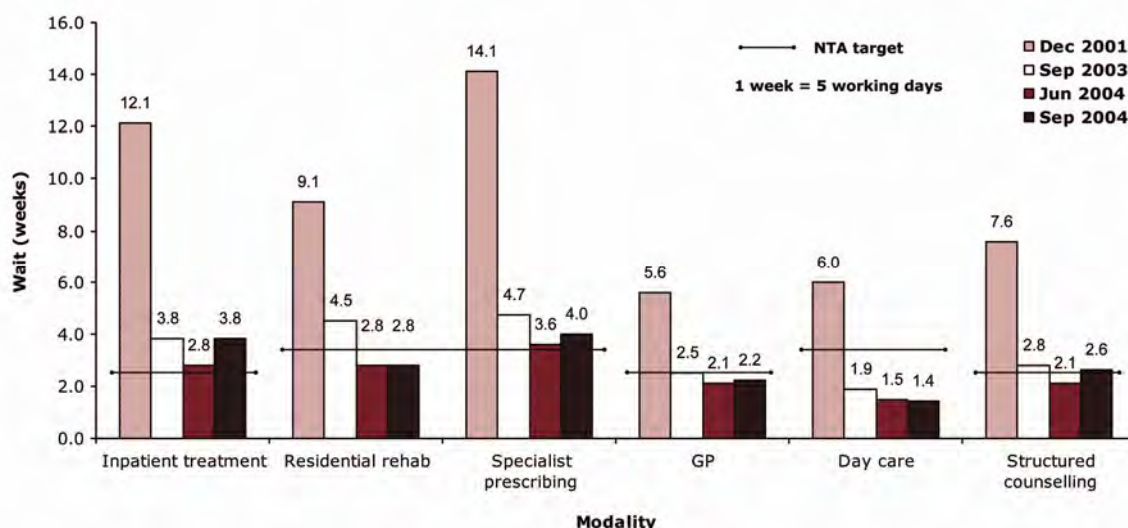


Figure 2: National average waiting times across treatment modalities during the NTA's existence

suggests that local factors and issues may have significantly skewed this information.

Nonetheless, there is no clear gender pattern that would indicate different rates of completion on the basis of referral for IPD treatment for drugs. However, a significantly higher number of men are referred for IPD than women across DAT sites involved in the study. In the previous year, the average waiting time for drug IPD among participating DATs was 5.3 weeks, compared to a current waiting time of 3.8 weeks, suggesting that the position in the DATs that participated is broadly consistent with the national picture as outlined in figure 2.

As can be seen from figure 2, the national picture for September 2004 shows the mean waiting time for IPD is just under four weeks and for RR just over two weeks. Therefore, the commissioners were broadly consistent with the national picture for IPD provision, but reported that they were performing slightly more poorly than the national average for RR provision.

When asked to express their satisfaction with provision in their area, precisely half reported that they felt that IPD need was met either "quite well" or "very well". Seventeen per cent of the commissioners were "not at all" satisfied and 29 per cent were satisfied only in part. Therefore, commissioners were generally more positive about the adequacy of the provision than were the clinicians who provided the IPD treatment. This inconsistency in perceptions of effectiveness merits further exploration.

However, some commissioners were very clear about the limitations of current provision, as reflected in the view that there was a need for:

"More NHS choice locally, and that IPD should be a treatment model separate from mainstream RR. There is also a need for separate male and female units and for more local services managed by drug and alcohol teams within inpatient settings, to encourage greater use of day programmes in the community."

Beyond the overall level of provision, the nature and quality of Tier 4 services were also challenged by some commissioners, with one commissioner asserting that:

"Locally there is a lack of formal inpatient provision, and services often use local mental health or acute inpatient facilities. Service provision therefore depends on 'goodwill' between services and while the local mental health service has worked closely with the substance misuse services, it does not provide the required amount of inpatient beds needed to meet demand."

Provision for stabilisation was much lower, with an average of only five places allocated per year in each DAT (range = 0–55). When asked to estimate how many people would benefit from additional IPD places in the DAT, the mean estimate was for 76 additional places per DAT (59 places for men and 17 for women). It is interesting to note that the demand for additional places for female drug users constitutes only 23 per cent of the total additional demand identified, challenging the

notion of a general perception of inadequate provision for female drug users.

Demand and uptake of residential rehabilitation services

Comparable data for demand, uptake and completion of RR services is shown in table 6.

The proportion of those referred for RR who go on to complete the treatment (35 per cent) is slightly lower than for IPD (where 43 per cent of those referred completed the treatment). At least in part, this would appear to occur because 92 per cent of those referred for IPD actually receive an assessment, compared to only 69 per cent of those referred for RR treatment. This may indicate a disjointed system in relation to the commissioning process involving community care, which results in unnecessary time lags in assessment and identification of places. Once again, there is little evidence of systematic variation by gender in this regard, but marked variations between DATs indicating huge inconsistencies in overall referrals, rates of admission and rates of completion, for both IPD and for RR across the DATs in England who completed the questionnaire. The average RR waiting times, reported by the commissioners who responded, was 3.7 weeks at the time of reply (around August 2004), with a mean waiting time in the previous year of 4.7 weeks, suggesting improvements in this domain.

With regard to the provision of RR, 66 per cent of the commissioners reported they were either partly or completely satisfied with the RR provided, with 18 per cent partly satisfied and 12 per cent dissatisfied. This is reflected in the relatively low numbers who are estimated as potentially benefiting from additional RR resource, with an average annual number of RR places estimated at 33 per DAT (20 males and 13 females). It is notable that a far higher proportion of the perceived added need for RR is for women (40 per cent) relative to the perceived additional demand for IPD, where only 23 per cent of the additional demand was perceived to be among female drug users, based on the mean estimates made by the commissioners who completed surveys.

Provision of aftercare for Tier 4 services

It was estimated that an average of 96 clients per DAT received aftercare in the participating DAT areas, of whom an average of 72 were attending structured daycare programmes. In the qualitative feedback, aftercare arose as an issue in several instances, with one commissioner arguing that there was a need for:

	Male	Female
Number of referrals for RR	35	16
Number of assessments for RR	25	11
Number of admissions for RR	21	9
Number completions for RR	14	6

Table 6: Rates of referral, assessment, admission and completion for residential rehabilitation per DAT for the 67 DATs completing the survey

“Specific focused resourced interventions as a treatment model. More local provision needed including NA [Narcotics Anonymous] in some areas. Open, flexible, local services which include group work and complementary work within a holistic approach.”

Assessment of needs

Only 34 per cent of the commissioners who replied reported they had carried out local needs assessments for IPD for drugs. Only 31 per cent had carried out needs assessment for RR.

Overview on unmet needs

While 28 per cent of the commissioners reported that there were problems in placing women in appropriate Tier 4 services, this problem was significantly exacerbated when the women had dependant children. Sixty-eight per cent of commissioners reported problems in placing women with children under six months of age in appropriate treatments and 65 per cent reported similar problems in placing women with older dependent children in suitable Tier 4 services. However, it is important to note that there are child welfare concerns relating to accommodating children within IPD or RR facilities and the welfare of the child must be considered as of paramount importance in decisions about treatment and effectiveness (this issue is discussed in detail in the ACMD report, *Hidden Harm* (ACMD, 2004)).

In comparison, 27 per cent of the commissioners felt there were problems in placing drug users from BME groups in appropriate Tier 4 services. This was seen as a problem for young people by 60 per cent of commissioners, for those with co-morbid mental health by 61 per cent of commissioners, for non-English speakers by 45 per cent and for those with disabilities by 25 per cent. In contrast, only 14 per cent of the commissioners thought there were problems in locating treatments for polydrug users, while 25 per cent

thought this was a problem for primary stimulant users.

However, the perception of difficulties in providing Tier 4 services for particular substance use types or groups of PDUs was not consistent across England, with marked regional variation in the commissioners' perceptions of the profile of problems. Therefore, as shown in table 7, in some areas there are problems for specific groups, but in others the problems of identifying Tier 4 spaces seemed to apply across the board. The issue of regional variation is picked up again in the overall needs analysis (see page 27), which examines the proportion of commissioners who believed that there were problems in their areas in providing appropriate Tier 4 services to each of the specified groups.

There are significant problems across regions in placing women with children, but there seem to be particular difficulties in London and the East of England region. For the other three populations identified in table 7, commissioners' perceptions varied markedly on a regional basis, with the placement of BME groups seen as particularly difficult in the East of England region, for young people in the East of England, North East and South West regions and for co-morbid mental health populations in the East of England region, London and the South West. The perception of problems with specific groups also arose in the qualitative interviews, with one commissioner suggesting that there was a need for:

“More services for crack users, particularly women. More help for drugs users who need an alcohol detoxification. More culturally appropriate rehabilitation services.

More facilities for woman with children.”

The placement of disabled people in Tier 4 services does not appear to present serious difficulties, although there are regional variations. For example, in the West Midlands region, 50 per cent of commissioners reported problems in placing this group, while in the East Midlands region, the percentage was zero. For non-English speakers, our results show two trends. For London, East of England, West Midlands and South West regions, there are perceived problems in placing this group in both RR and IPD provision. For the northern regions, Yorkshire and Humber, East Midlands and South East regions, fewer problems are perceived by commissioners. Providing Tier 4 treatment for the homeless is perceived by commissioners to be a serious problem in the North West (83.3 per cent), South West (57.1 per cent) and East Midlands (50 per cent) regions, but less so in other areas.

Perhaps surprisingly, commissioners across the country were less concerned about finding additional Tier 4 placements for either polydrug or primary stimulant users, with the highest number of placements for this group reported in the East of England region, for stimulant users, and in the South East region for polydrug users.

Extrapolating from JCM estimates

Of the JCMs who completed questionnaires, around half made estimates of the number of additional places (beyond those available in the last year) they felt would be beneficial each year for IPD and RR (as outlined in pages 28–32). The average estimate was that 51 additional places were needed annually for IPD in each DAT, with a lower figure of 33 additional places estimated for RR places per year.

Region	Women	Women with children < 6 months	Women with children > 6 months	BME groups	Young people	Mental health problems
London (n=9)	44%	78%	78%	25%	44%	70%
East Midlands (n=4)	25%	67%	67%	0	67%	33%
West Midlands (n=7)	29%	50%	40%	29%	43%	57%
East of England (n=8)	63%	86%	86%	71%	83%	100%
North East (n=7)	29%	71%	67%	17%	80%	60%
North West (n=6)	0	50%	50%	33%	67%	50%
South East (n=8)	0	71%	57%	13%	63%	50%
South West (n=7)	29%	71%	71%	29%	80%	71%
Yorkshire & Humber (n=4)	25%	50%	50%	0	25%	0

Table 7: Regional variation in commissioners' perceptions of the limitations in availability of Tier 4 treatment for different clients groups

However, the estimates varied widely ranging from 0–260 for IPD beds and 0–120 for RR beds.

There is a strong and statistically significant relationship between the existing number of IPD admissions from the DAT and the annual perceived additional demand for IPD admissions ($r=0.66$, $p<0.001$). In other words, the more that DATs currently commission IPD beds, the more they perceive the outstanding need to be, presumably reflecting a general satisfaction with what is provided at present. There is also a positive association, although not quite statistically significant ($r=0.43$, $p=0.06$), between the perceived need for IPD admissions and the perceived need for RR admissions. This may indicate that some commissioners have a stronger commitment to Tier 4 treatment as an effective use of resources, or that there is variation between DATs in the adequacy of current provision to meet perceived needs. There is also a strong and statistically significant relationship ($r=0.42$, $p<0.01$) between the estimated number of PDUs and the current level of provision of IPD beds, a relationship that did not occur for RR.

Using a simple arithmetical equation based on the reported anticipated demand, without weighting the DATs in any way, there would be an annual need for 1,479 additional places for IPD in the 29 reporting DATs and for RR, the cumulative estimate is 820 from the 25 JCMs who made estimates.

Twenty-five of the 29 commissioners who estimated the required additional resource also provided estimates of the number of places in the last year, totalling 793 individuals receiving IPD. To make this figure comparable, mean substitution was carried out for the four missing DATs, providing a total for the 29 DATs of 921 current places provided. To put this in a national context of need, the mean waiting time for IPD at the DATs who provided estimates was 6.9 weeks for the previous year, suggesting above average waiting periods. Nonetheless, these estimates would suggest that the projected increase in level of provision for these DAT areas would be a 161 per cent increase in the overall level of provision of IPD services.

For RR, the 25 agencies who estimated additional need for RR provided a cumulative total of 820 additional places. This compares with the existing total provision of 790 RR treatment episodes undertaken in the previous year within the same DATs. As only 23 of the 25 JCMs provided estimates of last year's provision, a mean substitution adjustment makes this figure up to a total of 859 places for

RR treatment in the relevant DAT areas, where there had been, in the previous year, a mean wait for RR of 4.5 weeks. This would suggest a total desired increase in the provision of RR treatment of 95 per cent. The overall implications of these projected increases in treatment provision are discussed at the end of the results section, however the following calculations are based on the estimates provided by the commissioners. The extrapolation from these estimates for IPD would be:

$$(1,479 + 951) \times 149/29 = 12,485$$

This would be the total estimate for additional need for IPD in 2004/2005. The equivalent figure for RR would be:

$$(820 + 859) \times 149 / 25 = 10,007$$

Therefore, using unadjusted calculations based on the estimates of existing need from the joint commissioners who replied, the total level of perceived Tier 4 need would be 22,492 treatment episodes for 2004/5, based on current levels of uptake and perceptions of the levels of unmet need.

Treatment plans: Documentary analysis

The NTA requires the production of annual treatment plans to measure treatment need in each DAT. These plans are designed to enable DATs to target local treatment issues and needs, and to utilise resources effectively. The brief analysis below examines the key issues in relation to Tier 4 addressed by these plans. The over-riding theme was the perceived need to increase capacity to meet the overall demand for Tier 4 services.

The themes of earlier sections were replicated in the need to improve staff specialisation and training, and in a perceived need to enhance the training and skills of the workforce around Tier 4. However, again echoing the commissioners' questionnaire, improved Tier 4 provision alone was not perceived to be sufficient, in that this should be done in the context of a more efficient system in which care pathways are adequately developed around Tier 4 provision. A number of treatment plans refer to the adequacy of data collection systems and assessment procedures. This is reflected in one treatment plan that asserts:

"There are major concerns about the procedure for assessment or how this affects the waiting times on residential rehab. There is little evidence of throughcare or aftercare planning and this was highlighted as a major priority."

The availability and quality of aftercare was highlighted as unsatisfactory (especially in relation to the volume of expenditure on Tier 4). "Aftercare" referred to specialist drug treatment, but also to the necessary social supports such as assistance with accommodation. Therefore, one treatment plan expressed the concern that:

"Unmet housing need is a major factor in the ability to benefit from detoxification and in sustaining abstinence."

The concern about accommodation was also expressed and is made more specific in connection to RR provision away from the local area:

"There is a lack of accommodation funded through Supporting People, for clients accessing aftercare

services. There is also a lack of formal discharge and aftercare planning, particularly for out of county residential rehabilitation placements."

This comment may have implications for community care management and care co-ordination, so that treatment can be integrated effectively into the overall care plan.

In terms of specialist populations, the treatment plans match the commissioners' and providers' assertions that the main omission is around the availability of treatment for women, especially women with children. To a lesser extent, they conveyed concerns about inadequate local provision for young people, homeless drug users, stimulant users and Drug Intervention Programme (DIP) clients. This tended to reflect the fear, in spite of recent evidence, that the DIP programme would undermine the treatment for other client groups. Therefore one treatment plan asserts that there is a clear need:

"To work with partners to accommodate childcare issues, which are acting as a barrier for clients wishing to access residential treatment services... to determine and document appropriate care pathways into young people's Tier 4 services."

There is a clear downward trend from 2003 to 2004 (to date) in average waiting time for RR, with six of the nine regions showing reductions and only one area showing an increase.

Again, the picture is relatively encouraging but inconsistent regionally, with three regions showing marked decreases in waiting times, while one region reported a marked increase in the average waiting time for RR treatment. However, as discussed in section 2, these indicators can only be used as markers of need when they are contextualised against supply and other process variables that will determine the flow of patients through the treatment process.

However, the treatment plans were not a useful source of data for this project and the information contained in them is extremely limited, in terms of either quantitative data or consistent information that can inform the research and analysis process.

Number of people reporting satisfaction with accessibility		
	Satisfied	Not satisfied
Methadone prescribing	93%	7%
Buprenorphine (Subutex®) prescribing	78%	22%
Inpatient opiate detox	36%	64%
Inpatient alcohol detox	33%	67%
Residential rehab	48%	52%
Structured daycare	63%	37%

Table 8: Views on availability of drug treatment services

Users and carers: Qualitative research

This section includes qualitative research findings from several research activities and events held for this purpose. These included:

- A focus group involving users and carers, commissioners, DAT co-ordinators and service providers (37 participants)
- A focus group involving only service users and carers (38 participants)
- A survey of service users and carers, drawn from those attending the users' and carers' event, and from one treatment service in the north-east of England.

The findings are not designed to be representative (owing to the small and opportunistic sample and incomplete responses in several areas) but do provide a useful snapshot of the views and experiences of several groups of users and carers, at least some of whom are involved in the treatment planning process or are actively engaged with

user forums and groups. (Some of the comments from the focus groups are based on the perceptions and beliefs of those involved in the groups and may be inconsistent with the findings presented in other parts of this report.)

Survey of users: Quantitative analysis

This research also includes the findings of surveys conducted with carers and users. The group was drawn from the Stockton-on-Tees area of the North East region (recruited via the support organisation PANIC) and the South East region (primarily the Oxfordshire users' network).

We received questionnaires from 136 service users and 36 carers. The majority (n=94) were recruited from the Stockton-on-Tees area and 23 from the South East region. The remainder were individuals who had attended the users and carers event previously discussed. Sixty-six per cent of the sample were male and 27 per cent female (seven per cent of returns were missing this information).

Twenty-two per cent of survey respondents had previously experienced inpatient detoxification and 26 per cent residential rehabilitation. The overall perceptions of treatment are presented in table 8.

This table shows a divergence among users about access to community services and access to Tier 4 services. While 93 per cent were satisfied with access to methadone prescribing and 78 per cent with access to buprenorphine prescribing, only 36 per cent were satisfied with access to IPD and 48 per cent with access to RR. To explore the issues around the relationship between supply and demand, the user participants were then asked to rate their experiences with any form of contact with inpatient treatment. The most striking finding, in contrast to the low levels of actual experience with Tier 4 treatment, is the high level of perceived need, with 69 per cent reporting feeling they had needed IPD at some point and 71 per cent reporting feeling they had needed RR, as shown in table 9.

This is also reflected in perceptions that both

	Inpatient detoxification		Residential rehabilitation	
	Yes	No	Yes	No
Felt they have needed	70%	30%	71%	29%
Have been offered	21%	79%	32%	68%
Put off by waiting times	45%	55%	51%	49%
Feel they would benefit from	55%	45%	61%	39%
Feel are appropriate for needs	58%	42%	63%	37%
Have been satisfied with post experiences	20%	80%	26%	74%

Table 9: Experiences and views of Tier 4 services

IPD and RR are appropriate for the needs of users – 58 per cent reported that IPD would be appropriate for them and 63 per cent that RR would be appropriate. Both forms of residential treatment were seen by the users as fulfilling some very important needs, with 46 per cent believing that an IPD would be necessary for them to achieve their ultimate treatment goals and 58 per cent feeling the same about RR. Similarly, 59 per cent of the users felt that IPD would help them to make a new start, a perception endorsed by 67 per cent with regard to the benefits of RR.

In general, the service users felt that IPD was beneficial because it was quick, safe and helped them become clean, but this was set against the fact that it tended to be too quick and was often set in unsatisfactory locations, on occasions populated by unfriendly staff. Similarly, RR was seen as offering the opportunity to experience “normal” life, understand the past, become more self-aware, and as a good way of improving self-esteem. However, the downside was separation from family and friends, the therapeutic environment – which was often seen as based on religious themes or on the 12-steps – and the perception that there was sometimes a lack of support.

A substantial proportion of the carers lived with the user either all the time (n=15) or occasionally (n=13). All the carers in the sample lived in the Stockton-on-Tees area except one, who also lived in the north-east of England.

Four of the respondents reported that the drug user they cared for was awaiting IPD and/or RR treatment. As with the users’ group, the majority of the carers were satisfied with access to methadone (82 per cent) or buprenorphine prescribing (69 per cent).

However, also paralleling the users, they were far less likely to be satisfied with access to IPD (43 per cent satisfied) or RR (56 per cent satisfied). They were also dissatisfied with the quality of these services, with only 21 per cent of those who had family experience of this reporting satisfaction with the quality of IPD and only 38 per cent reporting satisfaction with the quality of RR.

Carers identified the main advantages of Tier 4 services (as a whole) as respite, space – for them as well as for the users – safety and as a method of helping the user to come off drugs. Thirty out of the 41 who had been through the experience did report benefiting greatly from IPD, suggesting that, if nothing else, the user being in IPD or RR meant respite for the carer. However, ten (of the 15 who answered) felt they were not involved enough in either IPD or RR. They also felt there was no source of help or advice for carers, that there needed to be better family liaison, that there was a role for family support days and that the family could be involved in counselling sessions, something that had not been experienced by many of the carers, in spite of the services that do offer this facility.

Focus group: Aims and methods

The aim of this component of the study was to examine perceptions about Tier 4 services and to use this information to develop and interpret themes on behalf of key stakeholders, rather than to measure or illustrate prevalence. Themes examined included how needs are currently measured, special populations served and how the system could be improved.

Issue	Barriers to access/effective outcomes	What would help address this problem?
Referral	<ul style="list-style-type: none"> Inappropriate referrals: many drug users referred could be treated in the community People who have previously received Tier 4 services are unlikely to get a further chance Clients referred through the criminal justice system get priority and overwhelm the system 	<ul style="list-style-type: none"> Transparent eligibility criteria Better assessment and preparation Better relapse management and a willingness to offer several opportunities to experience residential rehabilitation Expanded provision (and possibly dedicated services) for DTTO and other criminal justice clients
Care planning and co-ordination	<ul style="list-style-type: none"> Lengthy waiting times and delays between IPD and RR and subsequent aftercare Stabilisation is not always available Clients are moved from RR before they are ready (often at three months) 	<ul style="list-style-type: none"> Better care planning and co-ordination and better client preparation for transition Wider range of services, including stabilisation, to be made available Length of stay based on client need/evidence rather than available funding
Service philosophy	<ul style="list-style-type: none"> Lack of client choice about treatment philosophy (most are oriented towards abstinence) Unrealistic expectations about relapse 	<ul style="list-style-type: none"> More client choice about service provision and an expanded range of treatment options Clear care planning and treatment goals Better staff training
Hidden/underserved populations	<ul style="list-style-type: none"> Perception of opiate-based services dominating, lack of childcare facilities, fear of social services intervention, poor outreach and cultural barriers 	<ul style="list-style-type: none"> Multicultural teams/communication with community leaders/better outreach Childcare facilities were requested although there are concerns that Tier 4 services may not be appropriate places for children Increased funding, better referral and services geared to treat polydrug users
Funding	<ul style="list-style-type: none"> Increasing "spot" purchasing limits referrals numbers Rising costs of residential rehabilitation Complex funding arrangements: different agencies control different funding streams 	<ul style="list-style-type: none"> More funding required but also better utilisation of existing resources
Settings	<ul style="list-style-type: none"> General detoxification on psychiatric wards is the norm 	<ul style="list-style-type: none"> Specialist services where appropriate (especially for dual diagnosis clients)

Table 10: Perceptions on Tier 4 services: service users, carer and professionals

Discussions in all of the focus group sessions were recorded, transcribed and analysed. The findings presented here provide a useful counterpoint to the quantitative findings presented in this report and highlight a range of different viewpoints, against which to set the quantitative results. Table 10 provides a summary of some of the key themes that emerged from the users and carers, as well as the stakeholder groups.

Overall views on Tier 4 provision

Table 10 highlights limitations in the range of options available in Tier 4 services and the need to make the system more responsive to the complex needs of drug users. The users and carers showed high levels of awareness

about drug treatment and Tier 4 in particular, many having directly experienced either IPD or RR. Despite the widespread recognition of the high costs of RR, frustration was expressed with the length of stay being too short to address the scale of the problem. Both providers and users felt clients were being "set up to fail", as the funding would run out when they were at their most vulnerable and least ready to cope with the demands of surviving in the community "clean".

One user said that this system felt like the "sword of Damocles". Both users and professionals complained about the number of inappropriate referrals (possibly as a result of problems with the assessment process), reflected in the volume of people referred to

