



*National Treatment Agency
for Substance Misuse*

RESIDENTIAL DRUG TREATMENT SERVICES: GOOD PRACTICE IN THE FIELD

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Residential drug treatment services: good practice in the field

Title: Residential drug treatment services: good practice in the field

Purpose: Good practice guide

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Target audience: Joint commissioning managers and all other partners in 149 DATs. Tier 4 treatment providers in the NHS and voluntary sector

Action required: Note examples of good practice and take local action if appropriate

Business reason: Meeting PSA 25 target; complying with Operating Framework or local authority equivalent; enabling achievement of vital signs

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The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The NTA works in partnership with national, regional and local agencies to:

- Ensure the efficient use of public funding to support effective, appropriate and accessible local services
- Promote evidence-based and coordinated practice, by distilling and disseminating best practice
- Improve performance by developing standards for treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce
- Monitor and develop the effectiveness of treatment.

The NTA has achieved the Department of Health's targets to:

- Double the number of people in treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

The NTA is in the frontline of a cross-government drive to reduce the harm caused by drugs. Its task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities. Going forward, the NTA will be judged against its ability to deliver better treatment and outcomes for a diverse range of drug misusers.

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1 Residential drug treatment services: a summary of good practice in the field

Good practice: the key points

Elements for commissioning effective Tier 4 treatment:

- Good partnership working, with close collaboration between drugs partnerships, drugs services, and local social services community care departments at a strategic and operational level
- Established routes into and out of treatment, with clear arrangements for preparing people for treatment, and for aftercare and reintegration
- Regular contract reviews with providers
- Good use of relevant data and other feedback to inform decisions on commissioning services.

Elements for providing effective Tier 4 treatment:

- Clearly established and effective exit strategies for clients when they leave treatment, including links with housing, education, training and other ongoing support
- Ongoing risk assessment and clear policies to keep clients safe following unplanned discharge and to reduce the risk of overdose
- Good structures for managing staff and helping them to deliver treatment, including clear supervision arrangements and meeting their training needs.

1.1 Introduction

Mention residential drug treatment services and many people will think burned-out celebrities and exclusive rehab clinics. The reality is more complex. Drug treatment comes in a variety of forms and settings, and the most important thing is that the help and support an individual receives is appropriate for their clinical needs and personal circumstances.

Local commissioners, working on behalf of local drug partnerships comprising the NHS, local authority care services, and criminal justice stakeholders, can choose from a broad spectrum of treatment options for their clients. Residential rehabilitation in a specialist centre is one of these. It is not the only answer for every problem drug-user, but it is suitable for some people at certain times in their lives.

There are about 200 voluntary sector or independent providers of residential treatment in England, but they are in turn only one element in a broad spectrum of treatment that is delivered in residential or inpatient settings. These include NHS services and are collectively known in the trade as Tier 4 interventions.

During 2007-08 the former independent health watchdog, the Healthcare Commission, inspected Tier 4 provision in England in conjunction with the NTA. The joint review, published earlier this year, showed the vast majority of these services provided treatment in safe environments, staffed by competent practitioners, with 59% scoring "good" and 34% "excellent."

Nevertheless the review also demonstrated scope for improvement in key areas. For example, it suggested that many of the 149 partnerships were not commissioning residential treatment in line with national guidance. It also found that a significant proportion of providers were not reporting data to the National Drug Treatment Monitoring System, so it was difficult to assess nationally whether existing provision was adequate.

In agreement with the Healthcare Commission and its successor, the Care Quality Commission, the NTA followed up the review with a programme of intensive help for the poorest-performing partnerships and providers, to bring them up to standard. It also conducted detailed interviews with those local drug partnerships and providers that scored highly. This report describes their best practice, and the key themes which emerged, and is being widely distributed so that all in the residential treatment sector can learn from their success.

We estimate that about 16,000 adults access Tier 4 services every year, about 10% of the target treatment audience, those dependent on heroin and crack. Most problem drug users – even those who need intensive treatment – can make positive changes to their lives while being treated in community settings and do not need to go into hospital or residential services. For a minority with severe problems, who struggle to make sufficient behavioural change in the community, inpatient detoxification and residential rehabilitation may be required.

As the NTA made clear in commissioning guidance issued last year, we expect partnerships to make active use of residential rehabilitation as part of the broad mix of recovery options that are available to help individuals recover from their addiction and reintegrate into society.

This report is based on interviews with the local drug partnerships and services that scored highly in the Tier 4 commissioning and provision theme of the 2007-08 Healthcare Commission and NTA service review. These partnerships and services described their practices, from which a number of key themes emerged. This report describes these themes, for commissioning and providing Tier 4 treatment.

The term 'Tier 4 treatment' covers inpatient treatment and residential rehabilitation. It is defined in *Models of Care for Treatment of Adult Drug Misusers: Update 2006*. See Appendix 4 for more.

1.2 National context

The NTA promotes a balanced drug treatment system, in which the treatment matches individuals' clinical needs and circumstances, and reflects their personal choices. This can include medication-assisted and abstinence-oriented treatment, and the opportunity for inpatient detoxification and residential rehabilitation.

Tier 4 within the treatment journey

Tier 4 interventions exist within a balanced local treatment system (even when clients access out-of-area tier 4 services) and are part of the range of treatment options available to all clients. To ensure Tier 4 interventions remain an option throughout a client's treatment journey, keyworkers and clients often discuss them during the care plan review, when client progress and planning interventions are being considered – ideally once every three months.

Tier 4 inpatient and residential interventions may be introduced at a number of key points during a client's treatment journey:

- Presentation – when clients seek abstinence and are assessed as appropriate, they are referred to inpatient detoxification, or residential rehabilitation (with or without detoxification)
- Care plan review – when clients are making progress but want to change the approach or pace of treatment; or when they are not making progress and require more intense and optimised treatment
- Treatment exit – when clients have made progress and need to take the final steps towards recovery and reintegration, perhaps via medication detoxification or residential rehabilitation.

Levels of need for Tier 4

Having ensured treatment systems have the capacity to offer clients stability and harm reduction, the NTA and drug partnerships are now concentrating on improving rates of recovery and successful exits from drug treatment – a move that may increase demand for a range of Tier 4 interventions.

Drugs partnerships will find they have to consider carefully the level of services they may need to supply to satisfy demand, and to ensure the type and quality of interventions meet the full range of client needs.

The appropriate place to do this is within the partnership needs-assessment process, which in turn feeds into the joint strategic needs assessment.

Performance management

Tier 4 inpatient and residential interventions require proper planning and monitoring if they are to meet the needs of commissioners and clients and provide successful outcomes. By working closely with local authority community care teams, drugs partnerships can oversee and manage placements with the same level of rigour they apply to community drug treatment contracts – notably via adequate service level agreements and regular contract and performance reviews.

Client placements into Tier 4 services can be funded in two ways. Firstly, through block contract arrangements with preferred providers, where local assessments conclude this is appropriate. Secondly, via spot-purchase, which can help maximise the range of services offered and so increase client choice. In either case, commissioners can monitor progress via performance-management requirements.

All Tier 4 placements are best integrated with the local treatment system, offering the same end-to-end service, from providing adequate assessment and preparation to ensuring appropriate aftercare or treatment continuation.

Developments in Tier 4 delivery

New models of residential treatment are emerging across the country. They include supported housing linked to structured treatment, and services tailored to local communities. New providers are also bringing with them innovative ideas and new ways to deliver interventions.

Among the services interviewed for this report, a small but growing trend was noticed in residential services whose clients live locally. These services, which include Burton Addiction Centre in Burton-on-Trent and the CRI St Thomas Fund in Brighton, have this focus for a number of reasons including meeting specific local needs, enabling family contact and having better resettlement and aftercare links.

In addition to these, there are other locally-focused residential services which are being established in various parts of the country. These are interesting developments in a fast-moving field and the NTA will monitor them closely.

Some current providers are at full capacity because they are seen to be effective, and responsive to the needs of clients and commissioners. The NTA supports new and innovative ways of providing structured treatment, especially when they meet identified needs and prove to be effective at improving outcomes for clients.

The purpose of this report is to share the good practice found during the Healthcare Commission and NTA joint-service review, and to encourage more effective service delivery in the Tier 4 sector in line with local need and demand.

1.3 Commissioning Tier 4 treatment

Providing access to Tier 4 treatment is an important part of commissioning a local drug treatment system and its treatment pathways. Local commissioners (including substance misuse commissioners and social services care managers) are responsible for ensuring that people who need Tier 4 treatment can access a range of services according to their needs. Interviews with high-performing partnerships provided the following:

Eligibility criteria for Tier 4 treatment

- Commissioners and service providers take a collaborative approach to developing Tier 4 eligibility criteria
- Eligibility criteria are usually based on existing local health or social care criteria. Developing them often happens alongside reviews and redevelopment of treatment pathways in partnerships
- Criteria are communicated through a written document. Some partnerships go further, running training sessions to familiarise local partners with the criteria
- Criteria are communicated to service users via keyworking, and local user groups and forums.

“ We’ve established a clear Tier 4 treatment pathway this year. One of the reasons for this was there were providers suggesting people with no clear criteria to inform whether they were ready for rehab.” South Gloucestershire

Developing and reviewing contracts

- In practice, there are a variety of different approaches to contracting Tier 4 providers. A mixture of spot and block contracting is most common, but some partnerships only use spot contracts

“ We want to ensure patient choice, so we place people outside block-contracted services depending on needs and desires.” Bristol

- Most spot contracts are for residential rehabilitation placements funded by local authority adult community care money, for which partnerships tend to use a standard contract
- Most partnerships use preferred provider lists for residential rehabilitation placements. These lists are reviewed, often annually, against data, feedback from service users and others, and service visits
- All partnerships express the importance of client choice in Tier 4 treatment.
- Reviews happened routinely for contracts with inpatient units and residential rehabilitation services, usually annually
- Most partnerships require Tier 4 services they commission to comply with NDTMS reporting and this is usually written into contracts. Many also insist on user involvement, making it a contract requirement and surveying discharged clients about their experience
- Some partnerships have collaborative commissioning arrangements in their region, where a number of neighbouring partnerships joint fund a Tier 4 service. This is particularly relevant for hospital inpatient services

“ The detoxification unit at Prestwich Hospital is a collaborative commissioning contract, across all the partnerships in Greater Manchester. We commission a set number of bed nights each year, which has usually been enough to satisfy the local demand in each area.” Stockport

- The pattern is to spend pooled treatment budget (PTB) money or mainstream NHS funding on inpatient treatment, and community care funding on residential rehabilitation. Some partnerships also use the PTB for rehabilitation placements.

Using data to inform Tier 4 commissioning decisions

- Partnerships use NDTMS data in contract reviews and related meetings, and in reports to joint commissioning and performance monitoring groups
- Commissioners also use a range of other data to get information on the treatment they commissioned. The main type is service-user feedback, and sometimes feedback from other stakeholders.

“Using data is a key element in monitoring and revising treatment systems.”
South Gloucestershire

Enabling post-Tier 4 treatment integration

- All the partnerships emphasise the importance of clear Tier 4 pathways, with aftercare as a vital element following treatment
- Most pathways require a clear care plan, with aftercare agreed before the client accesses either inpatient treatment or residential rehabilitation

“No clients go to detox or rehab without having a clear plan for what happens next. We have a number of aftercare options. There’s a day programme in the community and an open access aftercare unit. If people are struggling, staff are available almost round the clock and at weekends.” Birmingham

- The partnerships put a strong emphasis on local keyworkers and care managers staying in touch with clients throughout their stay in Tier 4 treatment. Keyworkers work with Tier 4 services and local agencies (housing support, aftercare providers, mutual aid groups, etc) to manage clients’ transition back into the community.

Funding for residential rehabilitation

- The key issue related to pooling budgets is whether partnerships have access to, and some control over, the community care budget for residential rehabilitation. Areas that have some control attribute this to good working relationships across the local authority, the drugs partnership and treatment services
- Partnerships believe the most important factor in funding rehabilitation and client placements is good partnership working, at strategic and operational levels:
 - At a strategic level, substance misuse commissioners work closely with partners in the local authority community care department on commissioning and purchasing residential rehabilitation services
 - At an operational level, the drug treatment commissioner or service manager has responsibility for rehabilitation budgets and placements

“Both at a strategic level and at an operational level, the drug partnership and services work very closely with the adult social care drug and alcohol team.” Hammersmith

- Another key factor is integration between community care teams and community drug treatment services, so that care managers work closely with drug treatment keyworkers on assessing and referring clients to Tier 4 treatment
- Most partnerships use funding panels, but some have stopped in the belief that they are bureaucratic. Other partnerships believe flexibility is the key factor, and ensure that panels operate efficiently and do not hold up treatment placements.

1.4 Providing Tier 4 treatment

Tier 4 provision covers a wide range of different treatment services. Inpatient treatment includes detoxification and stabilisation, and there are a number of different models of residential rehabilitation, ranging from large, traditional, out-of-area residential rehabilitation services to emerging, community-based, recovery-oriented houses. However, a number of common themes emerged from the interviews with high-performing providers:

Service information packs

- All the services have information packs, which fall into three main categories – packs for commissioners and referrers, client pre-admission, and clients on admission. It's believed these packs help clients to make informed choices about attending services, give them details on all aspects of the treatment programme, and reduce the risk of drop-out
 - “ *The pack lets the clients know what to expect in the residential programme, including the physical surroundings, the groups and sessions they will be attending, arrangements for regular support, care planning and review. It contains a copy of their selection criteria and admission information and charging policy.*” ARA Bristol
- All the services regularly review their information packs, mostly using service user feedback
- All the residential rehabilitation services want clients to visit the service for assessment before entering treatment. For inpatient services, some encourage pre-treatment visits, but this is not always possible due to speed of referral and admission.

Keeping waiting times low

- The waiting times for Tier 4 services depend largely on capacity. For many services, waiting times are a weak point because they are often full and have clients waiting to access treatment
 - “ *For prospective clients on the waiting list, we liaise with their care manager and the client is free to look at other options. However, if they want to, they can come for day visits to the service, until a bed is available.*” Littledale Hall
- Those that are often full also have methods for keeping clients engaged while they wait, such as regular phone contact or visits to the service
- Most services manage to ensure regular and consistent NDTMS returns because they have a named person who is responsible for submitting data.

Developing eligibility criteria for admission

- All the services have a set of simple, and largely common, eligibility criteria. They report few inappropriate referrals, and feel their clear criteria help with this
 - “ *We held a series of stakeholder meetings to review and agree our eligibility, admission and discharge criteria.*” Flaghead Unit, Dorset
- Most services, including all the residential rehabilitation units, require clients to visit the service for an assessment before they will consider a treatment place.

Making exit strategies work

- Most services do not accept clients unless they have a clear care plan in place, which specifies what will happen following Tier 4 treatment
 - “ We do an exit plan for all clients on admission, with a treatment completion date in mind.” Burton Addiction Centre
- The care plan is regularly reviewed by staff, in collaboration with the community keyworker who usually visits clients throughout their stay. Progress noted in the care plan helps to develop the aftercare plan
- Many services work with a range of local partners to help clients who want to move into second stage accommodation or stay in the same area.

Developing unplanned discharge policies

- Clients usually make an unplanned departure from Tier 4 treatment for two main reasons: either they are dissatisfied with the programme or they commit a serious breach of house rules
- Various policies are in place to manage unplanned discharges. These include making re-engagement attempts, giving harm reduction advice, and arranging transport back home, all underpinned by a risk assessment
 - “ If the client wants to stay in the area but end their treatment, we will arrange safe move-on accommodation and help them get resettled. We are continually looking at risk management.” ARA Bristol
- When a departure is unplanned, the services always notify the referring agency. The risk assessment is shared, along with any details of the client’s intentions.

Developing and using evidence-based treatment manuals

- Some services have developed evidence-based treatment manuals, setting out their treatment programmes and interventions, along with policies and procedures for delivering the programme
 - “ Our treatment manual is a comprehensive document describing the whole of our treatment programme. It means our staff can be clear about the objectives, materials and outcomes for all the elements of the programme and how then they can facilitate them.” ANA Portsmouth
- Most services provide harm reduction interventions – mainly access to blood-borne virus testing and vaccination.

Reviewing and adapting treatment programmes

- Most services routinely review their programmes, usually every six to 12 months
 - “ Staff are responsible for different parts of the treatment programme. They continually look for ways to improve their parts of the programme.” ANA Portsmouth
- They use a variety of different sources of information, including service user feedback, the evidence base, incident reports, clinical audit and peer reviews.

Managing and supporting staff in delivering treatment

- Key themes raised on this issue include a good induction programme, a strong commitment to staff training, regular supervision (individually and in groups) and regular audits of staff training needs.

“ We have training and development plans for the team and individuals. Our staff have monthly supervision and annual appraisals. These are task-focused, look at practical casework, and offer opportunities for critical reflection.” Littledale Hall

Ensuring ongoing risk assessment

- A client’s risk assessment is continually reviewed throughout their treatment, alongside the care plan

“ The risk assessment is an important part of this process – we need to pay particular attention to dual diagnosis and related medication issues, as well as histories of violence. Sometime we might need a bit more information, which we will ask for before proceeding with the placement.” Trelawn House

- If leaving is planned, the risk assessment is completed and passed back to the client’s community care manager or keyworker. If leaving is unplanned, a risk assessment is carried out to help the community services keep the client safe and to encourage treatment re-engagement.

1.5 Additional themes

Preparing for Tier 4 treatment

- A theme that emerged from a number of partnerships is the importance of clients being prepared for entering Tier 4 treatment, particularly residential rehabilitation

“ There’s a lot of preparation to let people know what they’re signing up for. We developed what we call a ‘focus on rehab’ group. Before we started the group, we were getting people turning up at the unit and leaving almost right away, saying “it’s not for me.” Birmingham

- Many partnerships have added specific elements to local treatment pathways to help prepare clients. They believe it has had a positive effect on their clients, who were better prepared and in many cases had better outcomes.

Locally-focused residential rehabilitation

- Although residential rehabilitation services usually take clients from across the country, a few services are more locally focused, taking all or most of their clients from their local authority. Nationally, this type of service is growing in numbers.

“ A locally-focused rehabilitation service has many advantages. For a start, it makes it easier for clients to maintain family relationships. Many have children and being in treatment locally it makes it easier for them.” CRI St Thomas Fund, Brighton

- Services have this focus for a number of reasons, such as meeting specific local needs, improving family contact, and having better resettlement and aftercare links.

2 Background

2.1 Purpose of this report

The purpose of this report is to highlight reported good practice in Tier 4 commissioning and service provision, based on interviews with the local drug partnerships and treatment services that performed well in the 2007-08 service review on Tier 4, carried out by the National Treatment Agency for Substance Misuse (NTA) and the Healthcare Commission. For more information on the service reviews, see Appendix 1.

2.2 How the report was produced

For this report, the NTA identified the partnerships and services that scored highest in the service review. The NTA policy team interviewed people in the high scoring partnerships, to gain information about their strategies and practices and determine what lessons could be learnt. Interviews were conducted with a range of staff, including joint commissioning managers, partnership strategy managers, social services community care managers, PCT leads, clinicians, and user and carer representatives. All of the partnership interviews included an on-site meeting using a set of questions as the basis for discussion. The questions closely followed the review questions and attempted to get the local 'story' behind the high rating scores.

The highest-scoring inpatient and residential rehabilitation services were also interviewed. Most of these were conducted by telephone, again using a set of questions as the basis for discussion. The interviews were usually with the service manager or other organisational leads

From the interviews, it was possible to highlight factors in local treatment systems that enabled these partnerships and services to perform well. A number of common themes were identified which were believed by the partnerships and services to be good practice in commissioning and providing Tier 4 treatment. These themes are set out in sections 3 and 4. There are also a number of case studies from specific partnerships and services, which showcase interesting, innovative or representative features that help to illustrate the

themes of the report. This was similar to the method used to produce previous NTA reports, *Good Practice in Care Planning* (NTA, 2007) and *Good Practice in Harm Reduction* (NTA, 2008).

A range of different types of local drug partnerships and service providers were interviewed for this report: in urban and rural areas, large and small partnership areas, and NHS and voluntary sector providers. For more details on these areas, and how they were selected, see Appendix 3.

2.3 National context

The NTA promotes a balanced treatment system in which the treatment any individual receives is appropriate for their clinical needs and circumstances, and reflects their personal choice. This includes both medication-assisted and abstinence-oriented treatment, including the opportunity of rehabilitation.

Tier 4 treatment (in-patient and residential rehabilitation) is generally best suited to those with more severe problems and complex needs, who have not benefited from community treatment. Numerous models exist – both 'traditional' and emerging – and it is the responsibility of local drug partnerships to ensure that they have the right range and volume of treatment options available to meet the needs of drug misusers in their area.

Since its inception, the NTA has been active in supporting improvements in the availability and quality of Tier 4 treatment. This work has involved an assessment of the national need for Tier 4 treatment (Best D, O'Grady A, Charalampous I and Gordon D (2005) National needs assessment for Tier 4 drugs services in England. London: National Treatment Agency for Substance Misuse), a review of inpatient treatment (Day E, Ison J, Keaney F, Buntwal N and Strang J, (2005) A national survey of inpatient drug services in England. London: National Treatment Agency for Substance Misuse) and working with partners across government on a £54m capital investment programme.

It has been known for some time that the commissioning of Tier 4 treatment requires improvement, and the NTA has produced guidance to assist with the commissioning and purchasing of these services. Models of Care: Update 2006 (National Treatment Agency (2006a). Models of Care for Treatment of Adult Drug Misusers: Update 2006. London: NTA) stressed the importance of commissioning Tier 4 since it is crucial to improve clients' journeys and to maximise treatment exits and access to abstinence-based aftercare. The NTA has also been aware of the pressures on residential rehabilitation services and has been actively working with providers on this issue and has encouraged local drugs partnerships to make more – and more strategic – use of Tier 4 treatment.

For in-patient treatment, and detoxification more generally, there have been three key pieces of national guidance issued in recent years: the 2007 Clinical Guidelines (DH & devolved administration, 2007), the NICE guideline on detoxification (NICE, 2007) and SCAN's in-patient consensus document (SCAN, 2007). All inpatient treatment for detoxification and stabilisation of drug misuse is to be provided in line with these.

Following the service review, local drug partnerships have used the results to develop action plans for 2009. NTA regional teams and strategic health authorities will monitor their performance against these plans. All inpatient and residential services were encouraged to develop action plans and share these with the commissioners of their services. The NTA has supported approximately 10% of the weakest performing partnerships and six inpatient or residential service providers in developing action plans. The NTA also delivered national workshops for the poorest performing services on improving aspects of delivery.

The NTA has been aware of a trend recently, where some of the expansion in the Tier 4 sector has a local focus; with more Tier 4 services in urban areas closer to where their clients live, which complement the provision run by services with national catchments. Some of the services

interviewed for this report had a similar focus, and this is noted in the report.

The priority for Tier 4 treatment remains on growing capacity to meet the needs of clients.

3 Commissioning Tier 4 treatment

3.1 Introduction

This section presents the themes of the interviews with the high-scoring partnerships. The headings reflect the questions that were asked, which were based on the criteria and questions from the service review which focused on commissioning of Tier 4 treatment.

Please note that ‘partnerships’ in this section refers only to the partnerships interviewed for this report, unless otherwise stated.

3.2 Awareness of the eligibility criteria for Tier 4 treatment

3.2.1 Background

The review checked whether local partners (including commissioning partners, service providers and service users) were made aware of the eligibility criteria for inpatient treatment, and the Fair Access to Care Services (FACS) eligibility criteria for residential rehabilitation. Partnerships generally scored well on this issue. Over half scored ‘excellent’ for awareness of inpatient criteria and about a third scored ‘excellent’ for residential rehabilitation. However, some partners (such as GPs and services users) were less aware of the criteria than others.

3.2.2 Themes

Although all the partnerships had been judged by the review to have established eligibility criteria and circulated them among their local partners, in reality it was less clear in some areas just how the criteria had been established and if they were well known locally.

However, a few areas had put a lot of work into the development and communication of their criteria, from which a few useful points can be made:

Development of criteria

Some partnerships had developed or reviewed their eligibility criteria in recent years, both inpatient treatment criteria and the FACS criteria for residential rehabilitation. These developments and reviews were usually done in partnership between

the commissioners, service providers and service users, through a process of meetings and consultations.

Recently established eligibility criteria were usually revisions of existing health or social care criteria which were modified to take better account of their local situation. One partnership had undertaken an equality impact assessment on the change of eligibility criteria to make sure that it did not adversely affect any particular client groups.

Often the development of criteria happened alongside the review and redevelopment of treatment pathways in the partnership, particularly Tier 4 treatment pathways. Some partnerships had included the eligibility criteria in their contracts and service specifications.

Communicating the criteria

At the most basic level, the review looked for written criteria, which were circulated between partners. Some of the partnerships had gone further. A good example of this was specific training provided across partner agencies about the criteria. This was particularly relevant in areas with a history of inappropriate referrals, which had prompted action to address gaps in the knowledge of health and social care staff. The training focused on the Tier 4 treatment pathway and the process of assessment, referral and entering treatment. The eligibility criteria, both for inpatient treatment and residential rehabilitation were a crucial part of this process and therefore featured prominently in the training sessions.

It was generally considered important to communicate the criteria with service users and this was done through individual keyworking, as well as through local users groups and forums. This was felt by the partnerships to have helped prevent service users demanding residential treatment when it was not appropriate for them at that time. Some areas had made efforts to communicate the criteria to carers so that they were better informed about residential treatment and drug treatment more generally. This way, families and carers were

more aware of the different treatment types on offer, particularly when residential rehabilitation is often the best-known drug treatment type and therefore the first type requested. This communication happened through local carers groups where they existed. Some partnerships included the criteria information on their websites.

Although the review found that GPs were often unaware of Tier 4 eligibility criteria, they were rarely directly involved in the referral of people to inpatient treatment or residential rehabilitation. If a GP's patient requested Tier 4 treatment, they were usually referred to the local specialist treatment service for assessment and further referral. However, some partnerships had made a particular effort to make their service providers aware of the criteria through local groups and forums, which included GPs with an interest in substance misuse treatment.

Case study: developing and communicating criteria for Tier 4 treatment

South Gloucestershire

"We've established a clear Tier 4 treatment pathway this year. One of the reasons for doing this was because there were providers suggesting people for rehab with no clear criteria to inform whether or not they were ready for rehab. There would be, say, 10 or 12 people being referred for community care assessment, eight of which were not appropriate for residential rehabilitation treatment. So we made the pathway more precise, and did training across all our local service providers, and user and carer groups to make clear what the community care assessment pathway is, so they're all well aware of what the pathway involves.

We've also set criteria, based on a revision of existing criteria and the new care pathway and circulated it and included it in the training so that everyone is now aware of exactly what the criteria are.

This knowledge has been very helpful across the local treatment system. Firstly, it helps services to

tell service users that they don't think they're quite ready for rehab yet because they haven't met the criteria. Secondly, it helps the community care coordinator to give the commissioners clear reasons why a rehab placement is needed. Thirdly, it helps users to know exactly what it takes to get rehab if they think they need it. Fourthly, it helps carers have a better understanding of what rehab actually involves. So we don't get so many carers phoning up saying "my son would be fine if you'd get him into rehab".

Hammersmith

"We have eligibility criteria, which were revised a few years ago. The DAAT changed the eligibility criteria for accessing residential rehabilitation placements some years ago. The reason for the revision was to ensure that the Drug and Alcohol Team were getting the right information from service users in order to make a good assessment of need. The comprehensive assessment was revised to ensure we were capturing information as part of the treatment effectiveness agenda. This was agreed at our local Models of Care Implementation Group to be used by all providers. This means that service users can have their assessments "follow" them between services to reduce unnecessary duplication.

As required we completed an equality impact assessment on the change to the eligibility criteria just to see if it would make have any adverse impact on any particular groups, but it seemed to work well for everyone.

Changes to the criteria were agreed by the Strategic Commissioning Group and cascaded to providers. Service users were consulted on the change to the criteria and informed of the final agreed document.. Further changes to accessing social care services introduced by the FACS criteria was relayed to all providers and local agencies in the borough through a robust consultation process. Service users were informed of the introduction of the FACS criteria through good work with service users through our service user involvement agenda, through the local service users forum and from our provider 'champions' in

each service. Using the involvement framework is a good way of getting information to service users as efficiently as possible.

We have substance misuse GPs as part of our GP shared care scheme and the introduction of the FACS criteria was distributed as part of a wider public consultation to GPs to ensure they are aware of what's going on and proposed changes. The wider GP cohort is harder to reach with our key information although we do regular mail outs. There has been a greater focus from the PCT over the last couple of years on substance misuse which helps to raise the profile among all healthcare professionals including GPs."

3.3 Development and review of contracts with Tier 4 services

3.3.1 Background

The review asked questions about the commissioning of inpatient treatment and residential rehabilitation and what was included in partnerships' contracts with Tier 4 service providers. Partnerships had to show that a number of elements were included in both their contracts and spot purchase agreements with inpatient and residential rehabilitation services.

Partnerships did not perform well on this issue with over half scoring 'weak' or 'fair' for commissioning of inpatient services and half scoring 'weak' for commissioning of residential rehabilitation. The areas of weakness were different for inpatient and residential rehabilitation, with spot contracts weaker for inpatient. The items that were least regularly included in contracts nationally were user and carer involvement, requirements for clinical audit and monitoring data.

3.3.2 Themes

The partnerships were asked how they developed and reviewed their contracts with Tier 4 service providers. From the discussions, there are a number of key themes to report.

Spot and block contracts

There were a variety of different approaches to contracting with Tier 4 providers. Some

partnerships used a mixture of spot and block contracting whereas others used only spot purchases. Those which used block contracts (the majority) said that this gave them stability and relatively easy access to treatment beds. Those, which preferred spot contracts emphasised the flexibility and wider client choice that this gave. Even the partnerships which used mainly block contracted services, still used spot purchased places occasionally if there was a specific need or to enable greater client choice. See case studies for more information.

Some partnerships had informal block arrangements where there was no official block contract in place, but there was an agreement with the service that if the partnership sent a certain number of clients, a cheaper price would be negotiated.

Since most spot contracts were residential rehabilitation placements from community care, partnerships tended to use a standard contract, usually a local authority one for care home placements. However, some had adapted generic contracts to add in some specific substance misuse elements (such as outcomes, NDTMS compliance, etc). Some partnerships used a standard contract but would append a specification for each client placement, stipulating a range of requirements that would form part of the contract. One partnership attached the client's care plan which then formed part of the contract.

Most partnerships also required residential rehabilitation services to be registered with the Commission for Social Care Inspection (now subsumed into the Care Quality Commission).

Some partnerships had been reviewing their commissioning of Tier 4 treatment against World Class Commissioning and felt that block contracts did not offer the level of personalisation required by the new commissioning standards.

A few partnerships highlighted difficulties with funding parent and child places because, although funding could be secured easily for the parent, the

funding for the child came from a different part of the local authority (children and families) and was not always easy to secure.

Preferred provider lists

There were also different views on the use of preferred provider lists for residential rehabilitation services. Most of the partnerships used these lists, as recommended by previous NTA Tier 4 commissioning guidance, but some had deliberately chosen not to. For those who had preferred provider lists, some were using long-established lists, but had sought to review the lists recently to ensure that the services they were purchasing continued to meet their needs and providing value for money. Others had more recently established their lists, and had worked with local partners and Tier 4 service providers to establish the list.

The lists usually contained a range of types of rehabilitation providers to cover different treatment options and give clients a choice of service. These included therapeutic communities, 12-step programmes, centres with skills development programmes, faith-based units.

Even the partnerships that did not use preferred provider lists still regularly purchased services from the same group of Tier 4 providers. These were usually a range of services that they had worked with in the past and had therefore had developed a good relationship.

Contract review

All the partnerships had routine reviews of their contracts with Tier 4 providers. This was particularly relevant for block contracts with inpatient units and residential rehabilitation services. These contracts were usually reviewed on an annual basis, but sometimes the reviews happened more frequently. Some partnerships did the reviews in collaboration with community service providers and service users.

Preferred providers were also kept under review, and it was common for local partnership staff, or care managers/keyworkers, to visit the services in

the list (e.g. annually) to check that the services were continuing to provide what they considered to be a good quality treatment programme, in a good environment and with the desired outcomes.

As well as these set reviews, partnerships would often carry out ongoing monitoring of the Tier 4 services with which they had block contracts, to ensure that the commissioned beds were being used.

Contract requirements

Most of the partnerships had included all of the required elements in their contracts with the Tier 4 service providers. Many of them said that they specifically required user involvement and NDTMS reporting requirements. Some had included requirements for clinical audit.

From a performance perspective, it was felt that NDTMS data was necessary for the partnership to review the activity and performance of the rehabilitation services that they were commissioning or purchasing. Therefore, most of the partnerships insisted that their Tier 4 services were compliant with NDTMS requirements. However, some partnerships did note that it was sometimes difficult to monitor NDTMS compliance for one-off spot placements.

For user involvement, many of the partnerships did not just write requirements for user involvement into their contracts, but also made a point of surveying their clients when they left the Tier 4 service. The keyworker would usually do this by giving the client a questionnaire which asked them about their experience and if they were satisfied with their treatment.

Many of the partnerships wanted the Tier 4 services to have a focus on harm reduction, particularly on preventing overdose and drug-related deaths, to guard against any incidents after the client left the service, whether in a planned or unplanned way

Sometimes existing contracts did not have all the quality requirements that the partnership would

like there to be, but contract renewal gave them the opportunity to revise the contracts and include the necessary elements.

Collaborative commissioning

Some partnerships had collaborative commissioning arrangements for Tier 4 services. This was particularly relevant for hospital inpatient services. Neighbouring partnerships had come together to plan and jointly commission specialist inpatient units.

Funding for Tier 4 treatment

The general pattern for funding Tier 4 treatment was for pooled treatment budget money to be spent on inpatient treatment and community care funding to pay for residential rehabilitation. However, some partnerships used PTB money for rehabilitation placements and others had substantial PCT contributions to the costs of detoxification and stabilisation services.

Case study: reviewing block contracts Bristol

"We've got a number of block contracts with providers. Many of these had been in place for a long time, with no end date and some of the contracts had never been used.

"Therefore we worked with the social workers and with service users to review the list of these block contracts reviewing our use of these services and their outcomes. The result was closing contracts with a number of services, but keeping many in place but now we have a better system of monitoring our contract with these and knowing the effectiveness of these services.

"We want to ensure patient choice, so we can place people outside these block-contracted services depending on needs and desires, but we let them know that our contracted services are well known to us and we can vouch for their quality and effectiveness better.

"On the subject of ongoing review, we have a rolling schedule of reviewing and we do it with service users and providers and it goes through a

commissioning group for signing off and so we always have a service specification within the service level agreement. We think it's a good system now; it's come through years of development and building up relationships."

Case study: preferred provided spot contracts

Bournemouth

"We don't have block contracts because it's based on that individual person's needs. It's all spot purchase. So, once we've identified what a service user needs and what their issues are we'll then source who should deliver the treatment provision

"We have a list of preferred providers, which is based on previous good working relationships and a range of quality indicators such as good outcomes, CSCI reports, compliance with Standards for Better Health, service user feedback and submission of NDTMS data. The services that we use on a regular basis we will actually go and visit personally at least once a year.

"We have a standard contract, and added to that contract have a range of different service specifications depending on what type of service is required, whether it is detox and primary rehabilitation, just primary, or one that includes secondary rehabilitation. When we make a placement we do it with a letter of agreement, which is for the individual client and which is underpinned by the standards in the contract."

Case study: collaborative commissioning Stockport

"The detoxification unit at Prestwich Hospital is a collaborative commissioning contract, which is across all the partnerships in Greater Manchester. We commission a set number of bed nights for drugs detox in each year, which has usually been enough to satisfy the local demand in each area. We have this facility available for anyone who needs detox locally."

Bournemouth

"As well as the Flaghead Unit being an inpatient resource for Bournemouth, Dorset and Poole

DAAT's under a joint Contract, we also have pan-Dorset contract for residential rehabilitation. We have developed this contract together. It's a standard contract with three different service specifications – one for detox and primary rehab, one for just primary rehab and one that's just secondary rehab, but it's the same contract, depending on what the provider produces. The contract went to the service users forums for agreement."

3.4 Use of specialist substance misuse inpatient units

3.4.1 Background

The review asked partnerships what proportion of each type of inpatient treatment was provided in their area. They were asked if patients underwent detoxification or stabilisation in specialist substance misuse units, medically monitored detoxification in a residential rehabilitation unit, or on a general medical ward or mental health ward. This question was asked because evidence shows that providing specialist substance misuse services, as opposed to detoxification on general medical or psychiatric wards, offers a more comprehensive service and has better outcomes.

This question scored well with the majority of partnerships scored 'good' (the maximum available), which indicates that most partnerships seem to be considering the evidence base when sending people to inpatient drug treatment.

3.4.2 Themes

As expected, the high-scoring partnerships all sent their patients to specialist substance misuse detoxification units or to detoxification as part of a residential rehabilitation programme. They were asked if they moved to specialist-only provision for inpatient treatment because of the evidence base.

Some of the partnerships had made a deliberate move towards commissioning only specialist inpatient provision, but for most partnerships the sole use of specialist services had pre-dated the commissioners' time in their position. For these areas, the commitment to specialist inpatient treatment has been a long-term one.

Some partnerships pointed out that there will always be some patients who are treated in general medical or psychiatric wards because there is a particular health need. People who have specific health or mental health problems may be detoxified in non-drug specialist wards if that is assessed to be the best place to meet all their needs.

3.5 Use of data to inform Tier 4 commissioning decisions

3.5.1 Background

The review had a particular focus on the data that was used to monitor Tier 4 services commissioned by each local partnership. Partnerships were asked about the data sources that the partnership used to monitor inpatient and residential rehabilitation services.

Although this criterion did not score badly overall (over half of partnerships scored 'good' or 'excellent') it highlighted some significant shortfalls, including lack of monitoring of overdose after discharge from Tier 4 treatment, and monitoring how many service users accessed community-based services after discharge from residential rehabilitation services.

3.5.2 Themes

The interviewed partnerships were asked how they use data to inform commissioning decisions about the Tier 4 services that they used. The following key themes emerged.

NDTMS data

Most of the partnerships used the NDTMS data that they requested from their Tier 4 providers. Sometimes this data was incomplete, but the partnerships had made an effort to ensure that their Tier 4 providers were returning NDTMS data. The data was thought to be useful, and was used in review meetings, reports to joint commissioning groups and performance monitoring groups. It helped the partnerships to understand if their Tier 4 services were performing to their satisfaction and if they were sending enough clients to Tier 4 treatment. One partnership had used NDTMS data to review its contract with a hospital inpatient unit.

Other data and feedback

As well as using hard data, commissioners used a range of other 'soft' data and feedback mechanisms to get information about the Tier 4 services that they used. The main type of this other data was service user feedback. Service users were encouraged by keyworkers and care managers to give feedback on the services they attended, whether they completed the programme or not. This feedback was formally recorded. This recorded feedback was valuable and was often used in reviews of contracts with Tier 4 services. Feedback from other stakeholders was also welcome, e.g. from keyworkers and other commissioners. Some partnerships used regional commissioning forums or cross-partnership care managers meetings to discuss Tier 4 providers.

Since many of the partnerships had small geographical areas or small populations, the numbers sent to Tier 4 treatment were relatively low. Given these numbers, these partnerships had a clear idea of who was in Tier 4 services at any one time and where they were in the treatment programme.

A number of partnerships had stopped using particular residential rehabilitation services after considering and following up on feedback from service users and other local partners.

Monitoring post-discharge overdose and reintegration

Most partnerships found monitoring data on post-discharge overdose and re-integration difficult and few had systems for collecting and using this data. Their response to how they monitored these issues focused mainly on local treatment systems and how they worked with clients to help them re-integrate and avoid overdose. Their care coordination systems would ensure that the client had a clear path back into community aftercare or treatment, and would be given all the necessary support and provided with harm reduction interventions if overdose was thought to be a risk.

Case study: use of data

South Gloucestershire

"Using data is the one of the key elements in monitoring and effectively revising treatment systems. We have several meetings including strategic and local where we look in depth at our data off of NDTMS aligned with our local knowledge to establish an action plan to resolve any glitches or anomalies in the system, these can then be raised appropriately with our Tier 4 providers present.

"As well as the NDTMS data, we use other data and feedback including interrogation of the local system. The regional joint commissioning group is a forum where we can discuss block purchasing of rehabs. The group discussion is useful as we can discuss regional rehabs, so that you get a South West-wide feel.

"We also ensure service user feedback is a core element in our care plan discharge procedures, on completion of rehab we make sure that the key worker helps the client to produce a feedback sheet. Feedback is another priority as it allows us to use this as an element of review, feedback sheets allow us to establish clear service user views when looking block purchasing future placements, this information will feed into our commissioning decisions."

Northumberland

"We've got information coming from NDTMS and were able to see when the Tier 4 placements were low and when they placements increase. We could demonstrate that there was an increase in placements to enable the budget to increase to meet that need and monitor the expected demand for the future.

"However, the NDTMS data on Tier 4 is not always very good, so we have to also rely on other locally-collected data, such as information from care plans, and data from the local care trust. We get most of our information from the data system, which holds the care plan information, but we also use feedback from service user forums. This helps us to demonstrate accurately what's happening

locally and inform the commissioning and purchasing of Tier 4 treatment.

“The development of our Tier 4 treatment system is founded on feedback from service users and the data that we’ve received locally and nationally. So the care planning, the pre-treatment and post-treatment interventions are all based on this data. Local discussions about what type of services to provide and commission (e.g. detox in rehab vs. standalone detox, and aftercare provision) rely on the data we’re collecting, and we’re talking about how to improve the numbers. What it boils down to is, how can we give the service user the best opportunity, using evidence-based treatment?”

“We definitely insist that all our Tier 4 services complete NDTMS and give us all the data we need. It’s even written into the spot contracts, and it’s a breach of contract if they don’t do it.”

3.6 Enabling post-Tier 4 treatment integration

3.6.1 Background

The review asked partnerships about their integration of community care pathways with the Tier 4 services they commissioned.

Partnerships also performed reasonably well on this issue, with around two thirds of partnerships ‘good’ (the maximum score) for having integrated pathways. However, again, some significant shortcomings were highlighted, in particular with drug partnerships not contracting their community-based services to undertake risk assessments with service users following unplanned discharge from Tier 4 treatment.

3.6.2 Themes

The high-scoring partnerships were asked how they provide aftercare and enable post-Tier 4 integration. The following key themes emerged.

Development of care pathways

All of the partnerships emphasised the importance of clear Tier 4 pathways, with aftercare as a vital element following Tier 4 treatment. Some had experienced problems with aftercare in the past

but had developed local systems to improve the options and interventions that were available to clients once they left Tier 4 treatment.

The pathways in most of the partnerships required a clear care plan with the aftercare set out before a client was allowed to access either inpatient treatment or residential rehabilitation. Funding panels would reject any application that did not have a clear aftercare plan specified. This plan would be developed as necessary as the client progressed in their treatment, but the essential element of aftercare would always be there, with a range of elements including re-integration, education and employment, psychosocial interventions, support groups, further keyworking and harm reduction interventions.

The client’s pathway would be managed so that they could progress as seamlessly as possible from one part of the pathway to another, including transfer from inpatient unit to rehabilitation centre, or from Tier 4 service to housing.

Keeping in touch and working with Tier 4 services

The partnerships put a strong emphasis on the work of the local keyworker or care manager staying in touch with the client throughout their stay in Tier 4 treatment. This was particularly relevant if the client was in rehabilitation for several months. The keyworker or care manager would visit the client regularly (usually once a month), get progress reports from the rehabilitation service staff and help to plan aftercare in partnership with the rehab staff. This would contribute to the ongoing care plan, aftercare plan and the risk assessment being developed in the Tier 4 service.

Good communication would be maintained with the Tier 4 service so that if there was an unplanned discharge, the keyworker could move quickly to contact the client and bring them back into local services once they returned home. The client would usually make their way back to treatment services fairly quickly and the keyworker would resume contact.

If the discharge was planned, the keyworker would work with the Tier 4 service, then with local agencies (e.g. housing and housing support, aftercare providers, mutual aid groups) to manage the transition back to the community. This was the usual practice since the vast majority of clients returned to their home area and the keyworker would continue working with the client. In the small number of cases where the client did not return, they would usually stay in the same area as the Tier 4 service, often in follow-on accommodation provided by the service. The community keyworker would work with the Tier 4 service to help this transition and transfer

Case study: aftercare projects

Birmingham

“We want to ensure that there is sufficient aftercare and support in the community when clients leave Tier 4. So, no Birmingham clients will go to detox or rehab without having a clear plan for whatever happens next.

“We have a number of aftercare options. There’s a day programme in the community and an open access aftercare unit. If people are struggling, they can call us, or come and see us. The staff are available almost round the clock and at weekends.

“We have a few aftercare groups. The groups vary – some are more focused on recovery, and some are more social. We have a group of people who have been through treatment programmes and have been abstinent for around two years. They attend those groups to give a perspective of somebody who’s been through the process. These groups run on evenings and weekends too.

“We encourage our clients to come back to Birmingham because of the aftercare programme. Now the programme is established and people are telling their friends, and peers about it and people generally aren’t wanting to stay away.”

Blackpool

“An important part of aftercare in Blackpool is COAST, which is an intensive, structured, non-residential programme, lasting at least 12 weeks.

It’s aimed at helping people develop healthy and productive lifestyles abstinent from drug dependency.

“The programme runs from Monday to Friday, from 10am to 4pm. All clients are expected to be totally abstinent, and are regularly tested to make sure this is the case. The programme is guided by experienced facilitators and volunteers, and there are cognitive, behavioural, emotional and physical interventions to challenge patterns of behaviour. Clients are encouraged to take responsibility for their lives. It’s a rolling programme so clients at different stages can share their experiences, and this helps to develop a supportive community.”

3.7 Funding for residential rehabilitation

3.7.1 Background

In the review, partnerships were asked how many community care assessments for residential rehabilitation were carried out in the past year and how the budget for access to residential rehabilitation services was managed.

The review found that partnerships were generally good at ensuring clients had funding to go to residential rehabilitation after an assessment that recommended access to this treatment. However, they were less good at managing the rehabilitation budgets in an integrated way, in partnership between the substance misuse commissioner and the local authority.

3.7.2 Themes

Partnerships were asked how they managed partnership relationships to ensure that community care funds for residential rehabilitation are brought within the remit of the drugs commissioning group. They were also asked how they managed their budgets to ensure that all or most of the people who were assessed as appropriate for rehab also received funding for the placement. The following themes emerged.

Pooling of residential rehabilitation budgets

In the review, the partnerships were asked if they pooled the budget for residential rehabilitation

with the adult pooled treatment budget for substance misuse. It was a mixed picture of those who said they had pooled this budget and those who had not. However, the key issue that emerged from the interviews was not whether this pooling had technically been done, but whether or not the partnerships had access to and some control over this budget. All of the partnerships had access and control, which they attributed to good partnership working and relationships across the local authority and the drugs partnership and treatment services

Most of the partnerships had enough funding from the local authority to pay for the rehabilitation placements that they needed each year. A few even had the placement funds ring fenced or protected for that purpose. In the few cases where the community care funding had run out (usually due to a higher number of placements than expected) the funds were 'topped up' with pooled treatment budget monies, which is in line with NTA Tier 4 commissioning guidance. None of the partnerships reported having to refuse someone a rehabilitation placement purely on the grounds of funds not being available.

Good relationships and partnership working

Across all the interviews, the most important factor discussed in funding rehabilitation and enabling client placements was believed to be good partnership working. Good relationships between different stakeholders in the partnership were continually stressed as vital to appropriate residential rehabilitation placements, particularly the relationships between the commissioner, the local authority community care department and local drug services. Good relationships were believed to be required at strategic and operational levels:

- Strategic level: substance misuse commissioners worked closely with partners in the local authority community care department on the commissioning and purchasing of residential rehabilitation service. In particular, most of the partnerships considered senior level commitment from social services to be essential, so community care budgets for

substance misuse rehabilitation could be protected and maintained year on year and, in some cases, even increased

- Operational level: local systems for the commissioning and purchasing of residential rehabilitation were believed to work well when the drug treatment commissioner or a service manager was delegated the responsibility for rehabilitation budgets and placements. Most of the partnerships had this kind of delegation where the commissioners or service managers were free to make decisions regarding Tier 4 placements, as part of agreements with the local authority. Another key factor highlighted was integrated community care teams and community drug treatment services, where care managers worked closely with drug treatment keyworkers on the assessment and referral of clients to Tier 4 treatment. In all of the partnerships, the drugs workers and social workers were either located in the same building, or have very close working relationships and a good knowledge and understanding of the client group.

Use of funding panels

There was a mixture of opinions among the high-scoring partnerships about the use of funding panels for making decisions on residential rehabilitation placements. Most areas used them, but some had stopped, believing them to be too bureaucratic. In these cases the responsibility for client placements in rehabilitation was delegated to the community drug service, working closely with social services care managers. In the areas, which had panels, flexibility was noted as the key factor. One area had a 'virtual' panel, which rarely met but communicated via email and telephone. The other areas had regular, usually weekly, panels attended by a small number of key staff: the substance misuse commissioning manager and usually managers from the local community drug service and senior social work staff. These panels operated quickly, endorsing the placements because the keyworkers or care managers had carried out high quality assessment and understood the eligibility criteria. Most partnerships said that only a very small number of cases had to be declined or sent

back for more work to be done. These partnerships did not consider their panels to be bureaucratic because they did not hold up clients' access to residential rehabilitation.

Case studies: rehabilitation funding Hammersmith

"Both at a strategic level and at an operational level, the drug partnership and services work very closely with the adult social care drug and alcohol team. The drug treatment service has a memorandum of understanding and a service specification with adult social care. The social care manager is on the commissioning body so has a voice in the development of services and plans for future work and performance are managed at quarterly contract reviews. Our contract reviews focus on performance against targets, use of budgets for block and spot contracts and managing demand against capacity for residential rehabilitation services from both Adult Social care's funding and pooled treatment budget top up funds. Historically we have been well resourced for residential rehabilitation and inpatient detoxification and our focus in 09-10 will be about delivering better outcomes from detox and residential rehabilitation not only for the service user experience but also to assist in achieving outcomes for the DAAT."

Northumberland

"We've got close collaboration across the DAT. The addictions service manager holds the social care budget for rehab within Adult Social Care Services, and the commissioner is monitoring this arrangement. In terms of governance arrangements, we have a partnership agreement about the delivery of a number of services. So we've got a framework for overseeing that and making sure that that happens. In Northumberland those partnerships have been in place for quite some time. We gave senior level buy-in to this, both on the DAT board and joint commissioning group."

Case studies: different approaches to funding panels

Virtual panel: Greenwich

"We have a virtual panel, which covers referrals to both inpatient and rehab. However, there is some evidence that a face to face panel would be useful. We wanted to make sure that decisions were quick, because people need to get to detox, and we don't want people waiting two weeks for a panel meeting. The panel has 48 hours they have to respond and this is normally fine.

"The panel consists of clinical members, team managers, a consultant psychiatrist, and funding members. The care managers have to demonstrate it on paper that the person is meeting the eligibility criteria. If there's an appeal against a decision the panel has made, we'd hear that face to face."

No panel: Northumberland

"We got rid of the panel. If we'd had the panel in place we wouldn't have scored so highly in the review. We felt it was restrictive; it created waiting times and was very complex due to the paperwork that we had to. It was felt that Tier 4 wasn't being promoted as an option, because the process put staff off.

"We were challenged by the NTA about our Tier 4 admissions being low. So the joint commissioning group reviewed the Tier 4 treatment system and one of the decisions was to remove the funding panel. Now the decisions about funding are taken by our community drug service, working in conjunction with social services. Our service users now have a better choice and Tier 4 is being promoted."

Panel: Bexley

"We have a weekly panel every Monday and we agree the funding there. The panel is chaired by the service manager of Bexley Drug and Alcohol Team, who has responsibility for care management and the placements budget. Bexley's two care managers also attend. Other professionals may be invited along for complex cases.

“The care managers will present a case, based on the assessment and liaison with other colleagues, such as probation, Children and Families and the local drugs service. They make recommendations to the panel and the case will either be agreed there or be sent back for further details to help the panel make the decision, such as aftercare plans being in place. Mostly, these cases are agreed at the panel because the work has been put in and the care managers know the clients very well.

“The process works quite seamlessly. Although we meet every Monday, if something is urgent we’ll attend to it sooner.”

4 Providing Tier 4 treatment

4.1 Introduction

This section presents the themes of the interviews with the high-scoring Tier 4 services. The headings reflect the questions asked, which were based on the criteria and questions from the service review which focused on provision of Tier 4 services.

Please note that 'services' in this chapter refers to the services interviewed for this report, unless otherwise noted.

4.2 Prompt and flexible access to Tier 4 services

In the review, Tier 4 providers were asked if service users had prompt and flexible access to their service and if there are good pathways between community services, inpatient services and residential rehabilitation services, so that Tier 4 services can operate as an effective and integrated component of drug treatment systems. Overall, residential rehabilitation services performed better than inpatient services on this issue.

4.2.1 Using service information packs to help inform choice

The services were asked how their information packs were used to help prospective service users make an informed choice and how these packs were reviewed. All the services had information packs, though these varied in size and content. Information packs across the services fell into three main categories.

Information given to care managers and other referrers

Some services had information packs developed specifically to give information to commissioners, care managers and other referrers about their service. This information would contain full details about the range of services that were on offer as well as information on how to refer clients to the service.

Information given to clients to inform them about their treatment

Clients were usually given a broad range of information so they could make an informed

choice. This information included details of the treatment programmes and what they involve (e.g. groupwork, individual counselling, skills training etc), house rules (e.g. no mobile phones, restrictions of freedoms, participation in housework, testing regimes) and other relevant information. These packs were usually in the form of brochures, which keyworkers or care managers would give to clients when they expressed an interest or were assessed as suitable for residential rehabilitation. Some services had information written by service users.

Information given to clients when they arrived at the treatment service

In some cases, this was the same as the information given out in advance of a client entering the treatment programme. Other services had more detailed information for clients on arrival at the treatment service, which had more information about rules and boundaries, a treatment 'contract' which the client would sign, complaints procedures etc. The view of these services was that they did not want to 'burden' the client with too much detail when they were making their choice, and only gave them the key relevant information in advance. The additional information would be explained to the client by a staff member on their arrival.

All these types of information packs were believed by the services to help clients make an informed choice about entering treatment their services. Through the information packs, the clients were able to be fully aware of what their treatment was going to involve, and this was thought to help reduce the risk of them dropping out of treatment.

Reviewing the information packs

All of the services said that they reviewed their information packs, some more regularly than others. Some reviews took place every six months, others every year or less often. Many services saw the introduction of a new programme element as an opportunity to review the packs, update the information and revise other parts of the information as necessary.

Most of the services saw service user feedback as an essential part of any information pack review. This was done in a variety of ways, including individual feedback, in-house user group feedback or taking information from questionnaires. Some services asked clients to complete a leaving questionnaire about their treatment, and these often included questions about the information the client was given before entering treatment.

Visits to Tier 4 services

All of the interviewed residential rehabilitation services said that they preferred each client to visit the service before they entered treatment. Obviously, distance could prevent some clients from visiting in advance, but it was always strongly recommended. The services mostly felt that it was this visit, much more so than the paper information packs that really helped a client to get a good knowledge of the service and what it would be like to stay there. At the visits, the clients would be able to ask any questions about their treatment and other aspects of staying at the rehabilitation centre, and they would be encouraged to talk to current residents without any staff present to get a 'service users' view' of what it was like to be in treatment there. It was felt that the whole visit experience was the best way to give a client an informed choice about going into treatment at these services.

For the inpatient services, some encouraged or allowed client visits before entering treatment, but sometimes this was not possible if the referral and admission happened quickly. Generally, the inpatient services did not place so much importance on visits, as the stays were much shorter than rehabilitation services (around 2 weeks). One inpatient service had a weekly preparation group, which they expected future patients to attend, both to provide them with information and also to demonstrate motivation.

Case studies

ARA Bristol

"Prospective clients can apply to us for an information pack. We have detailed information on our website and they can apply for a pack there.

The pack has a range of leaflets, not just for the residential rehabilitation service, but also other services we deliver, such as the structured day programme, aftercare, alcohol misuse service, housing support etc, some of which will be used by the clients in rehabilitation.

"The pack lets the clients know what to expect in the residential programme, including the physical surroundings, the groups and sessions they will be attending, arrangements for regular support, care planning and review. It contains a copy of their selection criteria and admission information and charging policy.

"There is a section on training, education, and employment and recreation, because there is a team which works on these issues with clients while in treatment.

"There is also background information, a mission statement, the complaints procedure and expectations on equal opportunities confidentiality etc.

"The packs are regularly updated and we recently revised all the information leaflets. Whenever any of our treatment documents change, the pack is updated.

"All our referral agencies have the packs in stock – both the local community services and the other Tier 4 services we get clients from."

4.2.2 Keeping waiting times low

The services were asked how they managed their waiting times, to keep them as low as possible. They were also asked how they handle the submission of data to NDTMS.

Managing waiting times

The waiting times for the interviewed Tier 4 services were largely dependent on their capacity. Interestingly, many of the high-scoring services' main weak point was waiting times because they were often full to capacity and had waiting lists for clients to access the service. However, it was a mixed picture, since some residential rehabilitation

services regularly had vacant beds. Those which had empty beds usually had little problem with waiting times, as clients could be admitted as soon as they were ready.

Managing the waiting lists was something that many of the services found difficult. Those that were often full and had waiting lists, had some methods to keep clients engaged while they waited, such as regular phone contact or an opportunity to visit the service. Some of the residential services spoke about the difficulties that arose from managing the seamless transfer between detoxification and rehabilitation, ensuring that there was a bed for the client even though the exact date of discharge from the detoxification unit was uncertain. Some services held beds for clients for a limited time to ensure smooth transfer.

Managing NDTMS returns

All the interviewed services completed NDTMS returns. Most managed to ensure regular and consistent NDTMS returns because they had a named person (or people) responsible for the submission of data. Some of the inpatient units in larger NHS trusts were able to take advantage of trust information and data services, but others still had named administrators or other staff with responsibility for NDTMS data.

Case study: Managing waiting lists Littledale Hall

“We usually have a waiting list for our service. For prospective clients on the waiting list, we liaise with their care manager and the client is free to look at other options. However, if they want to come to Littledale Hall, they can come for day visits to the service, until a bed is available.

“The day visits are very much like the visits that clients usually make as part of our usual interview and assessment process, but they can come again for as many of these visits as they want. We encourage the clients to do this, if they are still committed and motivated.

“Day visits are very structured and involve talking to the practitioners and residents, and seeing the

treatment available. Sometimes, if a client has been on a few visits they may be able to go into a treatment session if they feel comfortable about this and if they've discussed it with the treatment practitioner.”

4.2.3 Developing eligibility criteria for admission

The services were asked how they developed their eligibility criteria for admission and ensured these were being used consistently. The following key themes emerged.

Specific criteria

All the services had eligibility criteria, although most insisted that their criteria were simple and they would take almost any suitable client, depending on assessment. Their criteria were developed, some over a number of years, taking into account the unit's facilities, the staff competence and resources, as well as staff and client safety. Clients who would not be admitted to some or many of the services interviewed included:

- Schedule 1 offenders
- People with a recent history of violence or arson
- Clients with particular dual diagnosis needs, who needed specialist psychiatric care
- People under 18 years old
- Men with convictions for or histories of domestic violence.

Although the majority of the services (both inpatient and rehabilitation) gave similar criteria, the main reason for not accepting a client was if he or she did not want to engage with the full treatment programme, 'house rules' or other duties and responsibilities. Although some services claimed that they would take anyone assessed as suitable, almost none would take schedule 1 offenders.

The services reported very little in the way of inappropriate referrals, and felt that their clear eligibility criteria has helped with this issue. Some services had their eligibility criteria on the referral form, so they would be clear to any referrer.

Client interview

Most of the Tier 4 services, including all of the residential rehabilitation units, required the clients to visit the service for an assessment before they would consider a treatment place. This assessment would normally be done as part of a client visit to the rehab centre, although if it was particularly difficult for the client to attend, or if the client was in prison, the service would visit the client, or arrange for an assessment to be done. The services believed this interview to be an essential part of assessing whether the client was suitable for the service, and to check if all the eligibility criteria were met.

Case study: developing eligibility criteria Flaghead Unit, Dorset

“The eligibility criteria were developed in partnership with Bournemouth DAT. The managers at Flaghead sat round a table with the DAT and worked out what was going to be the criteria for entry, including the different criteria for drugs and alcohol.

“From these meetings, we then came up with a set of criteria for entry into Flaghead for both stabilisation and detoxification. We’ve also got criteria for exclusion, so if the client has a severe and enduring mental health illness he will be referred to the mental health services, because we can’t treat people with that level of need.

“We also held a series of stakeholder meetings with all the commissioners, service user representatives, other providers, referrers, and other people interested in the service to review and agree our eligibility, admission and discharge criteria.

“Following the consultation process they were formally written into a Trust policy document, which all referral services have access to.”

Acer Unit, Bristol

“The Acer Unit is a relatively new service, which started operation in June 2006. Eligibility criteria were set around the type of service that the Acer Unit was commissioned to provide, mainly a two-

week programme of detoxification or stabilisation. The eligibility criteria are defined by our service level agreement.

“There were previously inpatient drug treatment beds on a general psychiatric ward, and there were eligibility criteria for these beds. So the existing criteria were adapted for the new unit, but we also wanted to focus on the new treatment programme which has groupwork and therapeutic interventions. The eligibility criteria needed to reflect these given that it is a requirement for patients to attend groups.

“When we were developing the criteria, we went through a process of consulting staff across the local community drug teams, along with a consultant who worked with the community and inpatient services. This was particularly important since the Acer Unit is part of the same service as the community service. We had very good joint working to get the unit up and running.”

4.2.4 Making exit strategies work

The services were asked how they ensured that their clients’ exit strategy plans contain the appropriate level of follow-up support. The following key themes emerged.

Care plans including aftercare

Most of the services – residential rehabilitation and inpatients – did not accept clients unless they had a clear care plan in place, which specified what would happen following Tier 4 treatment. This was particularly relevant for the inpatient services, which had shorter stays and wanted to have somewhere to safely discharge the client in a planned way. This would be either residential rehabilitation or community support, but there would have to be something in place for the client to be admitted. Many services also insisted on having a contingency plan in advance in case of unplanned exit, so they knew all the key contacts back in the community to refer the client to when they left.

Developing the aftercare plan

For clients in residential rehabilitation, where the

stays were longer, there was still a need to have a plan for after the treatment, although it was recognised that this could change during the client's stay. The client's care plan would be regularly reviewed by the rehabilitation staff, in collaboration with the community care manager or keyworker who would usually visit the client throughout their stay (about every month). Progress in the care plan would be noted and fed into the ongoing care plan reviews and the development of the aftercare plan.

Working with partners

As well as working with the client's community keyworker, many services worked with a range of local partners to help clients who wanted to move into second stage accommodation or stay in the same area. Usually this involved working with local housing providers, homelessness services, education and training providers. Clients leaving would be linked in with local self-help and support groups, such as AA and NA.

Some services had their own resettlement teams or had an outreach worker to keep in touch with people once they left.

Case study: exit strategies

Burton Addiction Centre

"We do an exit plan for all clients on admission, with a treatment completion date in mind. The programme is 18 weeks minimum excluding detoxification, which is usually 2 extra weeks. In addition to this we also have a semi-independent living programme that can be accessed for 2-6 months for those who successfully complete the rehabilitation programme. On induction, the keyworker will talk about preparation for end of treatment, realising that rehab is not for everybody and clients may choose to leave. We're concerned that this happens safely and they have support options available when they return to the community.

"All people leaving get drug-related deaths leaflet and information on AA and NA across Staffordshire. If the client is leaving prior to treatment completion, they are referred back to the

original referring agency, usually a community service.

"For those who are leaving in a planned way, we have a resettlement team who work with clients to support and manage their transition back to the community. There are different options. We have semi-supported flats which some people go onto after finishing the rehab programme. There's also a floating support team which provides support to the client if they are going back home, or if they are going into supported housing. We work very closely with the local housing association and successfully have built a partnership that sees service users accessing their own tenancies following successful completion of their rehabilitation.

"We prepare an action plan with the client which includes drug-related support and which agencies are going to be involved in that. The clients can specify which services they want to use.

"There is also a range of social supports and clients are given opportunities to get training, education, employment. Local partners come into the service and discuss with clients and keyworkers. We have strong links with Connexions, Progress2Work and Burton College. We have set up work placements in a pilot project with the local Council. We are currently developing a local social enterprise with service users."

South London & Maudsley Trust

"On the referral form that we have there's a clear element of requiring a structured plan for discharge. Now, for the Acute Assessment Unit [a stabilisation service], that might be straight back to community team for a prescription, but since Wickham Park House [primarily detoxification] is more abstinence focused, we'd expect either a support councillor, a day programme or a rehab to be set up. We won't accept the client unless that's been done in advance.

"The community keyworker will have to demonstrate that this has all been arranged. For those going to rehab, we'd expect to see not just

rehab mentioned in the discharge plan, they'll have to demonstrate that their community care funding is in place. However, if a client is too ill or too chaotic to engage in community care assessments they'll do the assessment on the ward and then we'll dovetail the admission to rehab from there. We also ask for an unplanned exit plan, who will follow them up, who's their next of kin, so we know who's going to help them to stay safe and re-engage them into treatment.

"So we've got their ideal plan and the contingency. This is important, especially for the likes of pregnant women or somebody with dual diagnosis. Sometimes people deteriorate in their mental health during detox, so we need to know how we link in with the local services or how we can get them quickly into a psychiatric bed if they require it.

"All this has to be sorted out before they go onto an active wait for the service."

Trelawn House

"Everybody who comes in to the service will have a care plan developed by the community key worker or care manager. When the client has been in Trelawn for around about two weeks they will draw up a care plan with a key worker covering criminality, health, social functioning, family, social history etc. They will talk things through, decide on goals they want to achieve whilst they're here, and progress against these is updated regularly. There are internal reviews with two members of staff approximately every six weeks. They will also have at least one review with a care manager whilst they're here.

"Towards the end of somebody's stay there will be a review, which looks at where the client wants to go next and the full range of their needs. For housing, there are two main options: people who already have their own stable housing and want to go back there, and people who are homeless or not fixed abode, or they do have their own place and they don't want to go back because it's too dangerous, or it's where they did all their using, drinking and so on. So if they're going back to

their own place we look at the sort of support they can get in their community, which will be with their care manager, and might involve things like counselling support, a day facility, it voluntary work, further education, etc. Working with the care manager we can help to address issues about their tenancy and get that sorted if possible. If somebody's doesn't have their own place, or doesn't want to go back we look at referral to second stage accommodation, again working with the care manager to ensure that their range of needs are met. The second stage houses have house meetings and support and an emphasis in people going out and getting support in the community, moving from here to get more independence.

"The other thing that we do is a limited day facility for people who are ex residents. They usually come for one group and a key work session about once a week. It gives them a chance to maintain a little bit of a link here for a little while after they've left.

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ANA Treatment Centre, Portsmouth

"We have a big focus on education as part of our treatment programme and aftercare. We have developed strong links with Highbury College Portsmouth and developed an education pathway for all our clients who want it, particularly the clients in secondary rehabilitation and those who live locally. Most of our clients in secondary care take this opportunity. For those who live further away, they can continue courses at colleges back home through learning links. A range of courses are available and clients can collect points to enable them to attend further courses and even higher education.

"We also provide a range of aftercare services. One of these is that we facilitate family conference, to help introduce the client back to family life again. This is important given that often they will have

made significant changes to their lives and the family needs to be able to recognise this and adapt to the changes.

“We also provide unlimited aftercare, which is a drop-in service which that is run two days a week. It features structured themed workshops and group sessions plus the availability of one to one counselling. Any previous client can drop in for support, or even just to say that they’re doing fine.”

4.2.5 Developing unplanned discharge policies

The services were asked how they developed their unplanned discharge policies and how the policies and procedures work.

Reasons for leaving treatment

The services gave various reasons for clients leaving Tier 4 treatment in an unplanned way, but these can be roughly summarised as follows:

- Client dissatisfaction with programme – some clients lose interest in the treatment programme, or decide that this type of treatment is not for them. There may be different reasons for this including intensity of the treatment programme, lack of desire to comply with house rules and responsibilities. The client may express a desire to leave though some may just leave unannounced.
- Client asked to leave – a client would be asked to leave for serious breaches of the house rules or their treatment contract. This would be mainly be relapsing to use drugs or alcohol again, but also if they were violent or continually verbally abusive. If they continually refused to engage with the programme or their duties and responsibilities, or if they started a relationship with someone else on the programme they might be given notice to leave.

Policies to address unplanned discharge

All the services wanted to minimise unplanned discharges and the risks resulting from these. There were various policies in place to address this. For those clients who were not engaging with the

programme, many services would make particular efforts to re-engage them with the treatment programme. For those who had made their mind up to leave, the services would usually provide them with harm reduction advice – especially advice to prevent overdose. Some would pay for the client’s transport back home, and in special cases, might accompany them. A risk assessment would also be done.

Some services noted a difference between what they considered a ‘lapse’ and a ‘relapse’. A minor lapse into alcohol or drug use might not be considered by the staff to be serious enough to warrant exclusion, and the client would receive additional interventions to help them work on the issues that led to the lapse, and to prevent future lapses. However, the service might judge that what the client did was serious enough to count as a relapse, for which they would be asked to leave the service.

When a client left unplanned, the services would always notify the referring agency and inform the care manager or keyworker who would usually be given a risk assessment and information about what the client intended to do next (if known). The care manager or keyworker would then try to contact the client and re-engage them in treatment. If the person left midway through a detoxification programme, they would be put back in touch with community services to re-start or continue medication.

For those who let the treatment staff know they were leaving, the services would try to re-engage them. If this was not possible they would allow the client to leave, and inform the referring agency.

Case study: unplanned discharges

Rowan Ward

“We don’t accept a referral if the person hasn’t got a risk assessment, and we obviously review it when they come in. Any sort of risk they present to themselves or others decreases a lot when they are in treatment. A lot of the patients here have problems with anger so often we have a specific focus on this, and how they can handle their anger

issues. There might be a special agreement as part of the risk management plan. Good therapeutic relationships are key to lowering risk.

“If the patient was unplanned discharged, then the risk assessment would be updated and the information would immediately go to the community teams. We’d also contact any other relevant people, like probation.”

ARA, Bristol

“We have slightly different procedures for clients who we discharge for breaching their treatment contract and for the clients who choose to leave of their own accord.

“If someone breaches their contract, usually by taking drugs or drinking, two staff members do drug and alcohol tests and an on-the-spot risk assessment. If it’s out of hours, the people on call will attend. They will work out what the safest thing to do for both the client and the community.

“If we have to ask someone to leave, we will keep the client in local accommodation until the next working day when they will come into ARA and we will contact their care manager and next of kin. A full risk assessment is done at this point, and we ascertain what the next steps should be. This will include possible admission to one of our lapse places provided in a separate residential setting. During a period of up to six weeks the client will rejoin the programme but receive additional counselling and support especially focused around their lapse. After that period the option will be open for the client to rejoin the programme in full.

“If the client wants to stay in the area but end their treatment, we will arrange safe move-on accommodation and help them get resettled. We are continually looking at risk management.

“If the client wants to go back home, we will speak to their care manager and set up an appointment for when they return. We will then have a conversation with the client about the risks of low tolerance and provide information about safe using if they are going to do that. We will try

to ensure they have somewhere safe to go. We will work with the care manager on this, but sometimes we will rely on the next of kin for support. We will usually provide their fare back home, often by arrangement with the funder.

“If the client wants to leave, we will try to support them via some solution-focused interventions. We might try to persuade them to stay, and work out what could be different about their treatment if it’s a particular aspect of the programme that’s causing problems.

“The procedure is similar to the one for clients who we ask to leave - we’ll contact care manager, next of kin, do a risk assessment, inform the client of risk and try to minimise risk. We’ll also get the client to sign a form to make clear they are leaving against advice.

“All clients can access our aftercare services which provide flexible support for between six months and a year post treatment and may also be available beyond those parameters, whether they leave in a planned way or not. If they are returning home out of area, we can help arrange aftercare there.”

4.3 Providing evidence-based Tier 4 treatment

4.3.1 Developing and using evidence-based treatment manuals

The services were asked how they develop, update and implement their treatment manuals and particularly how they provided harm reduction interventions, education and training.

Treatment manuals

Even in the high-scoring services, not all had a clear treatment manual that set out their programme. However, some had put some effort into developing evidence-based manuals. These manuals set out the treatment programmes and interventions, along with policies and procedures for the delivery of the programme. They also usually had tools as part of the manual (e.g. questionnaires, handouts). The manuals were reviewed regularly (e.g. annually) or when a new

element or intervention was added to the programme. When additions to the evidence base came out, they would be fed into clinical governance structures or other structures developed by the service to review their manuals.

Some services did not have one manual, but a series of separate manuals or 'handbooks' for different aspects of their programme (e.g. a psychosocial handbook, a detoxification handbook, a groupwork handbook, etc).

Harm reduction

Most Tier 4 services provide or enable access to harm reduction interventions. Most of the services provided access to blood-borne virus testing and vaccinations – for the inpatient services this was usually undertaken on the unit, and for residential rehabilitation services, it was normally done in collaboration with local primary care services. Most of the services (all of the inpatient services and most of the residential rehabilitation units) would also provide harm reduction advice to clients who were leaving the service unplanned.

Case study: treatment manuals

Burton Addiction Centre

"We set up the treatment programme based on service users. We have an evidence-based manual and a treatment manual.

"The evidence-based manual has all the relevant background to the programme. It's divided into sections based on themes and each section specifies what the theme is (e.g. self-esteem), what the aim is and all the necessary evidence for that theme.

"The treatment manual has all the material for delivering the sessions, including the methods and resources (e.g. handouts) so that the therapies just needs to pick it up and deliver it.

"The manual has been around for a while, but it's grown and developed as the service has grown and developed. We're constantly reviewing the interventions, asking ourselves is the material still working. If not, is it the material or is it the delivery? We have processes for updating the

manual, which is mainly through our training days, where we look at the material and feed back. There are also various meetings which contribute to this process."

ANA Portsmouth

"Our treatment manual is a comprehensive document describing the whole of our treatment programme. It sets out the entire timetable with all the sessions, everything from one-to-one sessions to relapse prevention workshops. Having the manual means that our staff can be clear about the objectives, materials and outcomes for all the elements of the programme and also how then they can facilitate them.

"The manual was developed and written by our staff, there was a process involving the qualified counsellors and support workers. There was previously existing documentation of programme elements, but developing the manual meant that we could draw disparate documents together into one document and enhance them.

"In the development, we set a format for the manual, and once this was agreed, the counsellors wrote the different sections, with a strong focus on the objectives and outcomes.

"The manual has been put together in a way where it can be continuously updated. Each section is dated, with a review date specified, so we know when it is up for review. We have a continuous development policy, feed in from other contacts and partnerships. Can update the manual in an ongoing way – pull out and put in where necessary. We formally review the manual every year, but it is flexible enough to allow changes throughout the year, especially if new evidence emerges or we begin new projects.

"The manual is about to be reviewed through the EATA accreditation programme, which is undertaken by a panel of experts and closely scrutinises and reviews the service's treatment programme. In describing and evidencing the programme, it acts as a useful addition to CSCI registration."

4.3.2 Reviewing and adapting treatment programmes

The services were asked how they reviewed and adapted their treatment programmes in light of the evidence base and other audits and analyses.

Most services reviewed their programmes routinely, commonly every six to twelve months. Some services undertook annual audits of their service. Hospital inpatient services used the clinical governance procedures of their trust. A variety of different sources of information were used as a basis for programme reviews, including:

- Service user feedback – this was a vital source of information, and most services had established mechanisms for feedback from user groups and individuals, such as service user forums, questionnaires, individual feedback and facilitated sessions. This information was used to obtain detailed views on what was working for the clients, what was helpful and what they wanted changed.
- Evidence base – as the evidence base develops, some services wanted to ensure that their programmes and interventions were in line with the latest evidence. They would use the main evidence base documents, such as the 2007 Clinical Guidelines and NICE guidance, as well as research reports in their particular area of interest (e.g. psychosocial interventions).
- Incident reports – some services had incident reporting systems – the hospital inpatient services used their NHS trust's procedures, but some residential rehabilitation services had developed their own. These incident reports would be used in reviews to ensure that similar issues could be prevented or mitigated in future.
- Clinical audit – the inpatient services were part of NHS trusts which carried out regular clinical audits on their services – right down to care plan level – and this resulted in information that was used to help review services.
- Peer reviews – some services took part in peer review schemes with other similar services, where they reviewed each other as part of an external independent review group.

Case study: reviewing and adapting the programme

ANA Portsmouth

“There are ANA staff who are each responsible for different parts of the treatment programme. These staff form the management team and are tasked with continually looking for ways to improve their parts of the programme.

“We have a quarterly management meeting, where programme development is discussed. This is linked to continuous professional development through monthly management supervision. We look at the specific areas of our work and discuss emerging issues and what needs to be changed. We also gain knowledge about developments in the field and other relevant practice issues from both national contacts and networks and from local partnerships.

“Crucially, we get a lot of feedback from our service users. We have a weekly community group where the service users can comment on non-therapeutic matters. The therapeutic issues are addressed in their regular keyworking sessions, and there is opportunity for continual client feedback. All clients completing the programme do a review of their treatment experience. All of this information is gathered by the ANA staff and we use it to review our programme.”

Burton Addiction Centre

“A lot of elements contribute to our reviews of the programme. We've done external reviews before and are currently having one done. We also have our own processes for review. One of the main methods is service user feedback. We have ongoing consultation with our service user group and with individual service users. We also survey ex-users every three months after they leave treatment for a period of two years via a questionnaire. We also consult with families of users.

“We take complaints seriously and have a process of recording untoward incidents and reviewing these regularly with our clinical director to make sure these don't happen again and we improve what we do.”

4.3.3 Ensuring prescribing is in line with NICE guidance

This issue is primarily related to inpatient treatment services who used prescribing for medical detoxification and stabilisation. The services were asked how they ensured that their Tier 4 prescribing regimens were in line with NICE guidelines.

For hospital inpatient services, compliance with NICE guidelines was usually through the NHS trust clinical governance structures, which ensured the prescribing practice was in line with the guidelines. Doctors and other staff were aware of the guidelines and what they needed to do to comply with them.

Case study : Compliance with NICE guidelines

South London & Maudsley NHS Trust

“When NICE guidelines come out, we discuss them first in the addictions clinical governance meeting then it goes through the clinical governance process so we can decide about a division wide implementation plan and perhaps run a pilot to see how we’re going to achieve compliance. Usually there’s a project lead for each guidance or TA to ensure that it’s monitored. So far we’ve managed to work in line with the guidance, so it’s not been such a problem for us to adapt to new guidance.”

4.4 Effective, safe treatment delivered by competent practitioners

4.4.1 Managing and supporting staff to deliver treatment

The services were asked how they manage and support their staff to deliver the treatment programme. There were a number of themes raised.

Good induction programme –all the staff starting work in the services received an in-depth induction covering all aspects of the treatment programme and issues relating to working with the client group, as well as standard aspects like health and safety. There was often a focus on good attitude to the clients. Some services allowed new staff to shadow experienced staff for a while to acquaint themselves with the job.

Training needs analyses – many of the services carried out regular training needs analyses to work out current staff needs and identify any gaps in their knowledge, experience and competence.

Training is provided – there was a general commitment to training, and to following up that commitment by having a dedicated training budget and usually a training programme to ensure that all staff who needed to develop their skills were able to do so. Training used both internal and external courses. Training mostly covered the DANOS competencies and enabled the staff to achieve NVQs (e.g. NVQ in health and social care).

Regular supervision – all the services had regular, focused supervision for their staff. This included management supervision and clinical supervision (usually at least monthly) as well as group supervision and team meetings. This fed into the staff appraisal (usually annually). Services operating as part of NHS trusts or larger voluntary sector organisations had organisation-wide policies and structures for supervision to ensure that it happened regularly.

Case study: training and supporting staff Acer Unit, Bristol

“We provide new staff with a good induction programme, which usually takes a month. The programme covers a number of crucial issues such as running groups and includes visits to the community teams. There is also a focus on aftercare. Alongside the unit’s induction programme, the Trust has its own induction checklist which includes health & safety etc.

“Our staff have monthly supervision, both clinical and management supervision. They also have an annual appraisal. There is an appraisal process which forms a development plan and objective-setting for the year. The appraisal identifies training needs.

“Training is provided where needed. The staff have access to internal training, such as our regular clinical governance seminar. They can also access

other external, for example motivational interviewing or pharmacological training

“The Trust also allows for study days as part of the Trust-wide training and staff development programme.

“We have a comprehensive service user feedback questionnaire, which is anonymous and these are analysed. We identify what the main issues are and feed all the relevant points back to the staff, and these can be taken up in team meetings and supervision.”

Littledale Hall

“We have training and development plans for both the team and individuals. Our staff have monthly supervision and annual appraisals. These are task-focused, look at practical casework, and offer opportunities for critical reflection. As well as individual support, we offer team support (e.g. team meetings) to discuss current issues

“Also, every two months the staff have clinical group supervision, with an external clinical supervisor. This is a confidential and separate session and helps them to look at how well the team is working. Individual staff also have monthly external supervision with a counsellor.

“We always emphasise training and staff development. DANOS and NVQ3 are priorities. Staff can also access training for specific issues. We hold a staff development review and have a training development programme, which is regularly updated. Staff can attend courses, both in-house and external. Throughout the year, we have training and development days such as a psychotherapist coming in and doing training sessions.

“We also run a volunteer programme. There are a range of volunteers including maintenance volunteers and drivers to take clients to appointments. Volunteers also get monthly supervision. Ex-clients can be volunteers, but they have to be out of treatment for a year. There is a handbook for volunteers so they know what to

expect. We have also recently started taking social work students and medical students for placements.”

4.4.2 Ensuring ongoing risk assessment

The services were asked how they carry out risk assessments throughout a client’s treatment programme. The general process of risk assessment from the services’ responses can be summarised as follow.

Clients entering the Tier 4 services would have already undergone a risk assessment in the community, and this would be passed to the Tier 4 service on their arrival. The risk assessment would be noted on arrival and continually reviewed throughout the client’s treatment, alongside the care plan. When the client was ready to leave, the risk assessment would be completed and passed back to the client’s community care manager or keyworker. If the client left in an unplanned way, some services would carry out a risk assessment to help the community services to keep the client safe and to help with re-engagement.

Case study: Risk assessment Trelawn House

“The client’s care manager will usually do a risk assessment before the client is referred, and at the client interview and we will discuss this further. This information is taken to the team meeting where we will discuss the client and their place in Trelawn House. The risk assessment is an important part of this process – we need to pay particular attention to dual diagnosis and related medication issues, as well as histories of violence. Sometime we might need a bit more information, which we will ask for before proceeding with the placement.

“The risk assessment is part of the care plan and keywork and is regularly reviewed. As it’s all written up, the client can see it themselves. Reports are regularly given to care managers, all specific issues of concern are noted. The client will leave Trelawn with a fully updated care plan/risk assessment which will have hopefully vastly improved in their stay here.”

4.4.3 Maximising opportunities for successful completion

This was the poorest-performing question in this criterion, with a third (34%) of inpatient services and 43% of residential rehabilitation services scoring 'weak'.

This question was based on NDTMS data, so to get a fuller response, the high-scoring services were asked what measures they had put in place to maximise chances of their clients successfully completing their treatment programmes.

This question received the most wide-ranging responses of all. These were often related to the service's ethos, and the views of the interviewees, but a number of key factors can be highlighted:

- Staff being more flexible and more client-focused
- Responding effectively to client needs
- Encouraging clients and celebrating their ongoing success in treatment.
- Believe in the clients – believe that they can do it and let them know that.
- Respecting the clients
- Staff being listening and having an 'open door' policy
- Working closely with clients who want to leave
- Managing client expectations
- Focus on improving health and wellbeing
- Sports, leisure and activities, including outside trips
- Good partnership with local support services.

In addition to the good practice themes that correspond to the service review criteria and questions, there were further themes that emerged from the interviews, which were relevant to performance on Tier 4 commissioning and provision by partnerships and services.

5.1.1 Preparation for Tier 4 treatment

A clear theme that emerged from a number of partnerships was the importance of clients being prepared for entering Tier 4 treatment, particularly residential rehabilitation. Many of the partnerships had put specific elements into local treatment pathways to help prepare clients for Tier 4 treatment. Those that had believed that it had a positive effect on their clients and treatment system, that clients were better prepared and in many cases had better outcomes.

Some of these took the form of specific groups, which have been set up to focus on preparing people for Tier 4 treatment, covering issues such as what detoxification and residential rehabilitation are, different types of Tier 4 treatment and which may best suit the individual client, and understanding of the risks of drop-out. Often these groups would have input from ex-service users who had been through Tier 4 treatment and could offer their perspective.

Other areas had similar preparation done as part of the ongoing keyworking and care planning process, with the client having preparation support from the keyworker and other people as appropriate.

The preparation programmes also usually involved a visit to a Tier 4 service, which tied in with the service's desire to have the client visit and be assessed before entering treatment there.

As well as local partnerships having a focus on Tier 4 preparation and commissioning services to address this issue, some Tier 4 services also ran preparation groups or provided preparatory support for their prospective clients.

Case study: preparation for residential rehabilitation

Blackpool

"The Safer Blackpool Partnership has commissioned a service to help prepare people for residential rehabilitation. It takes the form of a group called Forward Thinking which meets for four sessions, weekly for a month. The group gives prospective rehab clients an opportunity to discuss and work through rehab issues, with peers, staff and ex-rehab residents who can give their perspectives on how rehab has helped them.

"Four sessions covering issues such as what rehab is, what they want to get out of their treatment, it, the different types of rehab centre and which might suit them best. They can also make use of a website www.detoxandrehab.org.uk which has been developed to help people thinking about Tier 4 treatment. Over the four weeks, the intention is that the group will have bonded and people will be clearer about support and rehab options.

"Clients will only apply for rehab after the four weeks have been completed. After this, they will be assessed and go through the process of getting funding for their placement."

Birmingham

"There's a lot of preparation beforehand to let people know what they're signing up for. We developed what we call a 'focus on rehab' group, and that started off as six two hour sessions spread over a month, where service users who were still using either alcohol or drugs could go through what rehab would mean to them. We found if we did those sessions, the service user would be better prepared for what was going to happen to them. Some people decided it was not for them.

"We're now normally doing four groups over two weeks. The programme was designed by social workers and psychotherapist, and service users and included a visit to a rehab of the client's choice.

"People now know better what to expect. Before we started on the focus on rehab group, we were

getting some turning up at the rehab unit and leaving almost right away, saying 'it's not for me'.

"The important bit with the preparation is that it links in with the aftercare. We have a group – we refer to them as 'peers' – who are people who have been through the programmes and are abstinent two years post-treatment. These people are involved in the focus on rehab groups, and they attend to give a perspective of somebody who's been through the process, and we think it raises people's expectations. It also provided support for people going through the treatment journey, at whatever stage they're at."

5.1.2 Locally-focused residential rehabilitation

Although residential rehabilitation services usually take clients from across the country, there were a few services, which had more of a local focus, taking all or most of their clients from the local authority area in which they were based.

These services had this focus for a number of reasons such as including meeting specific local needs, family contact and having better resettlement and aftercare links.

Nationally, there seems to be a growing number of this type of service and the NTA is keen to track the development of these to assess their impact and any implications this has for the future development of Tier 4 services in England. In addition to the services below which had a specific local focus, other services reported taking a significant number of clients from their own partnership area or region, and some had made strong links with the local area with regard to education, training, housing and aftercare support. There is another locally-focused Tier 4 service (detoxification and rehabilitation) due to open in Birmingham in 2009, and a number planned for other regions.

Case studies

Burton Addiction Centre

"The local focus is important because of our local support networks. Most clients are closely tied to

their community and don't want to move far away from home. We're keen on establishing recovery communities, where our clients can link in with like-minded people living in the same area, and starting this process while they're still in treatment is very helpful.

"We can also tap into local resources, such as Jobcentre advisers, the local college, Connexions etc, which is vital for the aftercare support. We're well linked in and well known to our social services, DAAT and PCT partners. These are important partnerships, where our partners they feel part of what we're doing, and they have some sort of ownership and part to play."

Harbour Centre, Tower Hamlets

"The Harbour Recovery Centre was commissioned by Tower Hamlets DAAT in 2006. It's a residential detox and rehab unit aimed at young, non-complex, non-injecting heroin users. The background to the service development was meeting the needs of the local population. We did a lot of work with the Bangladeshi community, and there was a real desire for a specific detox facility here. We did send people to detox before, usually out of London, but often it didn't work, and people came back quite quickly. These detoxes didn't really meet the needs of the Bangladeshi community, the young men who were heroin smokers.

"So the Harbour was designed to provide a locally-focused, culturally-appropriate service at an earlier stage in clients' drug-using careers. The centre takes self-referrals as well as people referred by the local social services care management team. The aim is to have quick, easy access to detox for Tower Hamlets clients. Early findings from a recent evaluation show that most of the Harbour patients are Bangladeshi heroin smokers, who haven't been successful in community treatment in the past. The same evaluation showed that about 70% of patients have successfully completed detox at the unit and gone onto post detox support."

CRI St Thomas Fund, Brighton

"We have found that having a locally-focused rehabilitation service has many advantages. For a

start, it makes it easier for clients to maintain family relationships. Many of our clients have children and being in treatment locally it makes it easier for them to see their children. This is particularly important as we treat a lot of women who are primary carers and for them to have regular contact with their children during the programme is crucial as they work through changes in their lives.

“We’re a vital part of the Brighton substance misuse treatment pathway, and we’re also part of the housing pathway. We work closely with local housing providers so our clients can move into local authority accommodation if necessary. There is also continuation of care through Tier 2 services

“Clients have a comprehensive package of education, training and volunteering made available to them. We have good links with local further education colleges and also crucially with other bodies locally like The Prince’s Trust, Nacro and the local football club Brighton & Hove Albion. Our clients are able to access one of the club’s training programmes.

“CRI run a peer mentoring programme where ex-users come in to mentor current residents and help them with various aspects of their treatment or re-integration, such as taking them out shopping.

“We have found that for our clients, having a local treatment programme, with community-focused aftercare was better in terms of outcomes. We have an open-door policy for all people who have been through our programme. They can come back to see us anytime they need any help.”

6 Appendix 1: Tier 4 service review

6.1 The 2007-08 service review

During 2007-08, the third joint Healthcare Commission and NTA substance misuse service review took place. This review assessed the performance of 149 local drug partnerships and focused on two themes: diversity and inpatient and residential rehabilitation services.

Due to the focus on Tier 4 treatment, this review was also delivered in cooperation with the Commission for Social Care Inspection (CSCI).

Within these two themes, the review established 11 criteria. These criteria were assessed using 40 questions with related indicators. Each question was scored on a scale of 1 to 4, using 'weak' (1), 'fair' (2), 'good' (3) or 'excellent' (4). These question scores were then used to calculate criteria level scores and overall scores for each local drug partnership, using the same scale. The criteria were developed in collaboration with a wide range of professionals (including service providers, commissioners and other experts) and service users

In previous reviews and for the diversity theme in this review, local drugs partnerships were reviewed and scored. However, since Tier 4 treatment services are usually commissioned and purchased from a national marketplace, often outside the local drug partnership area, this review assessed the Tier 4 providers and gave them each an individual score. The scores of the inpatient and residential service providers were also used to calculate the scores of the local drug partnerships, which commissioned their services. The services' scores were attributed to local partnerships in proportion to the amount of provision the partnership commissioned from these services.

6.2 The criteria and questions used in the review

The criteria for the review were based on existing standards used in the substance misuse field, mapped against Department of Health standards. This mapping provided a platform to support the development of criteria and questions.

The review criteria and questions were established based on these standards and existing guidance or statute, which service providers were expected to be compliant with. The criteria and questions also had to be measurable, therefore only questions that could be supported by systematically measurable evidence could be used in the review.

The NTA and the Healthcare Commission established an expert group to support the development of the review. The group included membership from all relevant professional and membership bodies, other regulatory bodies, NHS providers, voluntary sector providers, service users and carers, and commissioners. Members of the group were selected by an application process according to geographical spread, role, membership of the local networks (for dissemination and feedback), and relevant previous experience.

The assessment framework went through a process of peer review and piloting. The findings from this process were reviewed and used to inform redrafting of the assessment framework and questionnaires.

The criteria and questions for the Tier 4 review are below. Criteria 7 and 8 were applied to local partnerships to assess their commissioning of Tier 4 services and criteria 9-11 were applied to Tier 4 service providers.

Criterion 7: Local commissioning partnerships have effective commissioning and/or purchasing processes for Tier 4 in-patient interventions.

1. Are all members of the local commissioning partnership, service providers, and service users made aware of the local eligibility criteria for funding for Tier 4 in-patient provision?
2. How is Tier 4 in-patient detoxification/stabilisation/maintenance provision commissioned or purchased?
3. What is the proportion of each type of in-patient detoxification/stabilisation/maintenance service provided in the locality?

4. What data sources does the partnership use to monitor Tier 4 in-patient detoxification/stabilisation/maintenance provision and its outcomes?
5. How integrated are community care pathways with Tier 4 in-patient detoxification/stabilisation/maintenance interventions?

Criterion 8: Local commissioning partnerships have effective commissioning and/or purchasing processes for Tier 4 residential rehabilitation interventions.

1. Are all members of the local commissioning partnership, service providers and service users made aware of the local FACS eligibility criteria for funding for Tier 4 residential rehabilitation provision?
2. How are Tier 4 residential rehabilitation services commissioned or purchased?
3. How many Community Care Assessments for possible suitability for residential rehabilitation provision were carried out in the past year?
4. How is the budget for access to Tier 4 residential rehabilitation services managed?
5. What data sources does the partnership use to monitor Tier 4 residential rehabilitation provision and its outcomes?
6. How integrated are community care pathways with Tier 4 residential rehabilitation interventions?

Criterion 9: Service users have prompt and flexible access to Tier 4 interventions.

1. Does the service have an information pack that can be made available to service users?
2. How does the service's waiting times compare with national targets?
3. Does the service have eligibility criteria?
4. Does the service prepare exit strategy plans prior to, or on, admission?
5. Does the service have a policy for unplanned discharge?

Criterion 10: Service providers deliver Tier 4 interventions in line with an up to date evidence base that relates to the type of intervention or programme being delivered.

1. Does the service offer a programme delivered in line with an evidence-based manual?
2. What methods does the service use to review

and adapt its programme in the light of evidence/ monitoring information?

3. Are prescribing regimens in line with NICE clinical guidelines?

Criterion 11: Service providers provide Tier 4 interventions in a safe environment staffed by competent practitioners.

1. Does the service manage and support staff (including managers) to deliver Tier 4 provision in line with national guidance?
2. Do service users have risk assessments carried out on admission and as part of care planning?
3. What are the programme rates for successful completion (including planned discharge) of the programme for the last six months?

6.3 Results of the review

The full national results – including overall score, total score and the scores for each of the 11 criteria – were published for every local drug partnership area in England on the NTA website www.nta.nhs.uk in January 2009.

6.4 Using the review to improve performance

Local drug partnerships have used the results of this review to develop action plans for 2009. NTA's regional teams and strategic health authorities will monitor their performance against these plans. Furthermore, the NTA has supported approximately 10% of the weakest performing partnerships in developing their action plans.

In addition, six inpatient or residential service providers were also supported in developing action plans, and the NTA also delivered national workshops for the poorest performing services on improving aspects of delivery. All inpatient and residential services were encouraged to develop action plans and share these with the commissioners of their services. Local drug partnerships and Tier 4 services were given their individual results in November 2008 to begin planning and making improvements.

7 Appendix 2: Key documents and guidance

7.1 'Models of Care: Update 2006'

Models of Care for the Treatment of Adult Drug Misusers (NTA, 2006) is the national framework for the commissioning and provision of drug treatment services in England. It defines inpatient treatment and residential rehabilitation and sets out an outline of Tier 4 treatment provision.

7.2 The 2007 Clinical Guidelines

Drug Misuse and Dependence: UK Guidelines on Clinical Management (Department of Health and devolved administrations, 2007) are the national clinical guidelines for clinicians providing drug misuse treatment. They were fully updated and published in September 2007, replacing the 1999 edition.

The 2007 Clinical Guidelines provide guidance on the treatment of drug misuse in the UK. They are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most instances. The updated clinical guidelines cover detoxification in section 5.7.

7.3 Tier 4 best practice guide

In September 2008, the NTA published *Improving The Quality And Provision of Tier 4 Interventions As Part of Client Treatment Journeys: A Best Practice Guide*. The guidance summarises key challenges that currently face the Tier 4 sector and links the roles that each stakeholder group can play in jointly finding solutions and improvements. It 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.

7.4 Tier 4 commissioning guidance

In October 2006, the NTA published *Commissioning Tier 4 Drug Treatment: Guidance for Purchasers and Commissioners of Inpatient Treatment and Residential Rehabilitation*. This guidance follows on from the initial Tier 4 commissioning guidance, which was issued by the Home Office, the National Treatment Agency and the Department of Health in March 2006. The

purpose of this guidance is to update the initial guidance by providing further guidance on some of the details of commissioning Tier 4 treatment. This guidance is also intended to support the objective to put in place robust regional and sub-regional Tier 4 commissioning structures.

7.5 'Models of Residential Rehabilitation'

Also in October 2006, the NTA published *Models of Residential Rehabilitation for Drug and Alcohol Misusers*. This document aims to clarify the nature of residential rehabilitation services and the range of services that should be available to residents of a local drug and alcohol partnership area, to inform the commissioning of residential rehabilitation at local, regional and supra-regional levels. It also complements guidance on commissioning Tier 4 treatment. The model upon which this document is based was drawn up in consultation with key government and service provider stakeholders.

7.6 Residential rehabilitation retention study

In June 2005, the NTA published *Research Briefing 10: a National Survey of Retention in Residential Rehabilitation Services*. The survey found that factors associated with better client retention were: fewer beds, less housekeeping duties, higher service fees and between one and two hours per week of individual counselling. Total structured activities of more than 39 hours per week were associated with lower overall retention rates. Higher rates of single room occupancy and higher ratios of staff to clients were also associated with improved retention profiles in participating services. The key conclusion is that residential rehabilitation services can be structured to improve retention rates and that, while client characteristics are important, services must take considerable responsibility for the retention outcomes they achieve.

7.7 'National Survey of Inpatient Drug Services'

Also in June 2005, the NTA published *A National Survey of Inpatient Drug Services in England*. The

survey was commissioned because at the time, little information existed on the trends in inpatient services for stabilisation or detoxification of patients who have substance misuse disorders. The survey provided information on the level of provision and provided a snapshot of the current clinical practice, in terms of number of services, location, availability of beds, types of cases managed, available resources, types of services and ranges of outcomes.

Residential Services: National Minimum Standards for Care Homes for Younger Adults and Adult Placements. The toolkit was commissioned by the NTA as a contribution to its workforce development strategy and to enable residential service managers to meet the human resource standards of the National minimum standards for care homes for younger adults and adult placements.

7.8 'Opiate Detoxification in an Inpatient Setting'

In June 2005, the NTA published *Research Briefing 9: Opiate Detoxification in an Inpatient Setting* by Dr Ed Day. This short research report looked at studies on inpatient opiate detoxification and its outcomes. It covers the client group served, cost-effectiveness, the treatment setting, factors associated with good outcomes and the range of services.

7.9 Tier 4 needs assessment

In June 2005, the NTA published *The National Needs Assessment for Tier 4 Drugs Services in England*. The work of the needs assessment was to determine the need for different types of Tier 4 services across England. The assessment complemented the national survey of inpatient drug services and interviewed residential rehabilitation service providers and commissioners. It covered regional variations and made a number of recommendations for developing and enhancing Tier 4 treatment provision across the country.

7.10 Summary of inpatient report and Tier 4 needs assessment.

In June 2005, the NTA published *Tier 4 Drug Treatment in England: Summary of Inpatient Provision and Needs Assessment*, which was a summary report combining the key findings of Opiate detoxification in an inpatient setting and the Tier 4 needs assessment,

7.11 Staff development toolkit for residential services

In May 2003, the NTA published the *Staff Development Toolkit for Drug and Alcohol*

8 Appendix 3: Partnerships and services interviewed, and rationale

8.1 Partnerships interviewed

The following partnerships were interviewed about their Tier 4 commissioning and service provision:

- South Gloucestershire
- Bexley
- Hammersmith and Fulham
- Northumberland
- Blackpool
- Birmingham
- Greenwich
- Windsor and Maidenhead
- Bristol
- Bournemouth
- Stockport
- Telford and Wrekin
- Tower Hamlets
- Southampton

The following services were interviewed about their Tier 4 service provision:

Inpatient services

- Acute Assessment Unit (AAU) and Wickham Park House (both South London & Maudsley NHS Foundation Trust)
- BSDAS Acer Unit (Bristol)
- Burbage Ward (Sheffield)
- CADAS and Genesis (Dorset PCT)
- Flaghead Unit (Dorset)
- Rowan Ward – inpatient Services (South London & St George's Mental Health NHS Trust)

Residential rehabilitation services

- Littledale Hall Therapeutic Community (Lancashire)
- Burton Addiction Centre (Staffordshire)
- Trelawn House (Croydon)
- ANA Treatment Centre (Portsmouth)
- CRI St Thomas Fund (Brighton)
- Vale House Service Stabilisation Services (Hertford)
- ARA Residential Program (Bristol)
- Inward House (Lancashire)

8.2 Rationale for selection

8.2.1 Partnership selection

The highest scoring partnerships in the Tier 4 theme of the service review: those scoring 20, 19

or 18 (maximum score was 20), were automatically selected for interview. There were 11 of these partnerships.

There were 12 partnerships, which scored 17 for Tier 4 in the review. Since time and resources did not allow us to interview all of these, a simple selection rule was applied, which involved looking at the partnerships' total score. Of the partnerships, which scored 17, four of these had higher total scores and overall scores than the others. Those scoring 38 and 36 in total, which equated to an overall score of 4 were selected.

Some of the selected partnerships were also selected to interview for the diversity good practice report and these interviews combined both themes. The interviews used a set of questions based on the questions used in the service review as a basis for discussion. The interviews were recorded and transcribed.

8.2.2 Tier 4 service selection

Given the nature of Tier 4 treatment, much of which is provided out of the area where it is commissioned or purchased, most of the partnership interviews would not include providers of Tier 4 treatment. Therefore, it was necessary to identify the top-scoring inpatient and residential rehabilitation services and interview them separately.

The top-scoring inpatient and rehabilitation services either scored 12 (the maximum) or 11 across the three provider-specific criteria. Time and resources did not permit visiting all of these, so they were interviewed by telephone. These interviews involved a conversation with a key member of staff, usually the service manager, using a set of questions based on the review questions. Notes were taken and the interviews written up.

9 Appendix 4: Definitions of Tier 4 treatment

Tier 4 treatment is defined in Models Of Care for Treatment of Adult Drug Misusers: Update 2006 (pages 45 and 46) as follows.

9.1 Inpatient treatment

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/assisted withdrawal from illegal and substitute drugs and alcohol in the case of poly-dependence
- 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 planned 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 or vaccination (if appropriate) for hepatitis B, C and HIV
- Other harm reduction interventions
- Educational work
- Physical and mental health screening
- Linking inpatient treatment to post-discharge

care, which 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 for supporting progression to abstinence.

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

9.2 Residential rehabilitation

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 is a range of residential rehabilitation services, which include:

- Drug and alcohol residential rehabilitation services whose programmes to 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 (e.g. for drug-using pregnant women, drug users with liver problems, drugs 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

- Some drug-specific therapeutic communities and 12-Step programmes in prisons
- “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 nearby 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 (e.g. 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, the client should be supported by their keyworker (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.