



Public Health
England

Protecting and improving the nation's health

Residential rehabilitation: state of the sector in 2014

Report of a survey of providers and commissioners of residential services

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Executive summary

In early 2014 PHE surveyed residential rehabilitation (rehab) providers and substance misuse commissioners to get a snapshot of the current state of the rehab sector. This was in response to concerns within the sector that changes to commissioning for drug and alcohol treatment was having an adverse impact.

The overall picture from the survey, carried out nine months after structural reforms, was broadly positive. The majority of commissioners said that they intended to keep investing in residential rehab services, and local funding for rehab was reported to have remained much the same after April 2013. Over three quarters of residential providers said they have either increased or maintained occupancy in the past five years.

The survey also raised questions about the extent to which this largely positive picture may continue. Most commissioners reported that social care budgets continued to be the primary funding stream for residential rehab and, although many had maintained levels of funding, a degree of uncertainty had emerged about longer term sustainability at a time of reducing local authority budgets. However, many providers said they were apprehensive about the future and how they deliver services was being adversely effected in some cases.

In light of these findings, PHE will carry out a follow-up survey in early 2015 to see whether the situation has changed. Residential rehab is an effective component of local alcohol and drug treatment systems and should be available to people who need it, wherever they live.

1. A snapshot of the rehab sector

The purpose of this report is to give a snapshot of the state of the residential rehabilitation sector in 2013-4 against a background of changes to the commissioning landscape for substance misuse services. It is based on an online survey of residential rehab services and local authority commissioners carried out in January and February 2014. Both groups were asked a set of relevant questions about how they provide and commission residential rehab services. The survey was developed in consultation with the residential rehab expert group, convened by the Recovery Partnership¹.

¹ The Recovery Partnership is comprised of the Substance Misuse Skills Consortium, the Recovery Group UK and DrugScope and provides a collective voice to government on the challenges faced and outcomes achieved by the alcohol and drug sector.

1.1 Background to the rehab survey

Before April 2013, commissioning arrangements for residential rehab were often complex in many local areas. The majority of rehab placements were funded by the local authority adult social care budget and in some places this was not well integrated with the commissioning of the wider drug and alcohol treatment system, leading to unclear care pathways.

In other areas, the social care arrangements were well integrated with substance misuse commissioning, and assessment, referral and funding processes were joined up with the local treatment providers at operational and strategic commissioning level. Largely due to the relatively high costs of residential rehab, many local authorities have operated a funding panel (or similar decision-making mechanism) to review individual cases against their criteria for residential placements.

Moving public health commissioning to local authorities in April 2013 provided the opportunity for commissioning functions to become fully integrated. At the same time, there was sufficient concern about the impact of the commissioning reforms on the residential rehab sector to prompt this survey of commissioners and providers, to get a sense both of how the sector has fared in recent years and how the changes have affected it.

1.2 Who responded to the survey?

In total, there were 60 responses from providers and 81 from commissioners. There are around 90 residential rehab services that report to the National Drug Treatment Monitoring System (NDTMS), and 152 top-tier local authorities in England.

This is a reasonable response rate and we believe the results are likely to be broadly representative. The findings are in line with the recent alcohol and drug review, carried out by PHE and the Association of Directors of Public Health, to which 94% of commissioners responded.²

However, it is a self-selected sample and therefore the results cannot be taken as the views of all commissioners and rehab providers. For example, the commissioners who responded may be more committed to rehab and so more likely to have responded.

² Review of Drug and Alcohol Commissioning: A joint review conducted by Public Health England and the Association of Directors of Public Health (PHE, 2014).

2. Funding

The most significant issue to emerge from the survey for both providers and commissioners was funding.

2.1 Breakdown of funding streams

Historically, funding for residential rehabilitation has been an adult social care responsibility and funded from community care budgets. In many areas this has been supplemented by contributions from the drugs pooled treatment budget (PTB). Since the inception of the public health grant (PHG) some local authorities have taken the opportunity to pool previous community care funding with the drug and alcohol spend from the PHG. In a third of cases responsibility for residential care sits within adult social care and is not managed directly by substance misuse commissioners.

2.2 Changes in providers' funding

Providers said that the largest funding source they receive is adult social care (reported by 70%). Over two fifths (42%) said they receive funding directly from the public health grant, and local authority supporting people funding was received by 20% (even though the supporting people ring fence was removed in April 2009). Half (50%) receive funds from private clients.

Over half (56%) of providers reported that the adult social care funding they received hadn't decreased – it had either increased (18%) or hadn't changed (38%) in the past five years; 44% reported a reduction in adult social care funding.

Over a third of providers (36%) reported a reduction in funding from the PTB in the four years before this funding stream ended in March 2013, but 45% said their PTB funding stayed the same in this period.

'Other funding' was the only category where the majority experienced a rise (55%). This category mainly included charitable sources (eg, charitable trusts and lottery funding).

2.3 Effects of funding changes on providers

Over half the providers said changes in funding have led to changes in staffing (58%). Of those who had seen changes, slightly more reported decreases in staffing levels (41%) than increases (32%). Fifteen per cent of providers reported that they had the same numbers of staff but operating at a reduced cost or grade profile and 12% had remained the same.

Changes in funding have had a range of other impacts on providers in addition to staffing levels. Providers reported that:

- they are taking more complex clients
- clients are staying in rehab for shorter periods of time
- they are spending more time on contract tenders and marketing the service
- they are not able to improve their facilities
- they are depending more on charitable donations and other ways of generating income
- less funding is available for aftercare, once the rehab programme has been completed
- they are not able to cover all the costs of the service provision

There was some concern among providers about the future. When asked about the situations they expected to face in the next few years over half (57%) expected future financial difficulties.

2.4 Commissioners' rehab funding has largely remained stable

The survey asked commissioners how their funding streams for residential rehab have changed over the past five years. The general picture was a consistent one with little or no changes over the past five years, which includes the period since April 2013. However, there were indications from commissioners of changes ahead.

The commissioners' survey identified that since April 2013, adult social care funding is still the largest funding stream (73%) used to fund rehab placements, with 62% also using the public health grant. Six per cent still identify supporting people funding.

2.5 Most commissioners are not planning to reduce rehab funding

Just over half of commissioners (51%) foresee their rehab spending remaining similar to current levels, at least in the near future. Another 16% think their spending will increase. The remaining third think it will decrease. Although there was a desire and even a commitment from some commissioners to maintain rehab spending, many were unsure about the future beyond the next year or two ahead.

2.6 Local authority cost savings may reduce rehab spending

Those who expected decreased rehab funding saw pressures on local authority budgets and the likelihood of reduced social care funding for rehab as likely reasons. Some commissioners reported that they have started to reduce their budgets already, and others expected to follow suit in the next year or two.

Some commissioners thought that rehab was an expensive option and hard to justify in the face of local authority efficiency savings, particularly when a few believed that outcomes did not always justify the cost. Other commissioners suggested that local

authorities may narrow their eligibility criteria for rehab funding and that alternative, less expensive, community-based options would be considered first where appropriate.

Many commissioners expected to be commissioning more community-based abstinence services and some reported that improvements in local community-based services was a reason for sending fewer clients to out-of-area rehabs.

2.7 Stable funding now, but there may be decreases ahead

The commissioners who expected funding to remain at similar levels did so because they have secured funding for the next year or two, but most believed that there would be no further increase and some thought that decreases in funding were inevitable eventually. Many of these areas had consistent demand for rehab in recent years and were keen to maintain this status quo in funding for as long as possible, but acknowledged they were operating in an environment of reducing local authority budgets and competing demands for the social care budget. The view was expressed that if current levels of residential placements are to continue then there may need to be savings found in the system, such as reducing the length of clients' rehab placements.

The 16% of commissioners who expected an increase in funding in future were doing so because they believed this was the best way to achieve more recovery in their local treatment system. However, there was a view even in this group that increases in funding had been secured only for a year or two, and they were less convinced about future sustainability. Other commissioners highlighted that they were spending more public health money on rehab to make up for a shortfall in social care funding, but they were also uncertain about the long-term future of this approach.

3. Referrals and occupancy

After funding, the second most prominent issue providers said is affecting them is occupancy and related concerns about referral rates.

3.1 Total numbers in rehab

The numbers of people reported to the National Drug Treatment Monitoring System (NDTMS) over the last five years shows a general stability in numbers of people accessing residential rehab for alcohol and drug problems (see table 1). These trends follow the pattern of numbers accessing alcohol and drug treatment overall.

The table shows the numbers of people in residential rehabilitation as recorded by the NDTMS. To put these in context, the number of people in alcohol treatment in 2013-14 was 114,920 and the number in drug treatment was 193,198. People in residential

rehab have consistently made up about 4% of the numbers in alcohol treatment and about 2% of the numbers in drug treatment in recent years. These figures do not include private clients, as they are not reported to the NDTMS.

Table 1. Numbers of people in residential rehab

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Alcohol	3,950	4,325	4,132	4,268	4,134	4,368
Drugs	4,711	3,914	4,232	4,026	3,974	3,935

3.2 Providers’ occupancy levels have generally been maintained

Over three quarters of rehab provider said they have maintained occupancy at similar levels (41%) or increased it (35%) over the course of the past five years. Under a quarter (24%) said their occupancy levels had decreased.

For the providers who experienced an increase in occupancy, the most common reason (62%) was an increase in referrals from the local authorities that regularly refer clients. Nearly half (48%) reported an increase from all referral sources and 43% said they had an increase in referrals from private clients.

For the providers reporting decreased occupancy, the main reason (71%) was a decrease in referrals from all the local authorities they deal with, with 52% experiencing a decrease in referrals from the areas which regularly refer clients and 20% a decrease in referrals from private clients.

In the past year, the vast majority of providers responding to the survey reported no decrease in bed numbers – they have either increased their number of beds (35%) or retained them at the same level (59%). Only 6% of providers reported that their bed numbers have decreased. Some of those who had increased their bed numbers reported being able to do so due to having received government capital funding for recovery services and one provider reported raising their own funds to do so.

3.3 Some providers have fears about future referrals

There was some concern among providers about referrals in the future. Over a third (38%) expected fewer referrals; 30% expected increased competition for clients from other rehabs and 46% expected increased competition from community services. However, against this, there were 43% of providers who expected growth in referrals and expansion of their service.

3.4 Numbers of people entering rehab has largely not decreased

The majority of commissioners (85%) reported that over the past five years, the numbers of people they have funded for rehab has not decreased. Of these, over half (51%) say it has stayed the same and 34% say it has increased.

The commissioners that had increased the numbers of people accessing rehab said that they did so because they were able to increase current levels of funding (70%) or in response to a greater local need (61%).

The reasons given by commissioners for maintaining levels of access to rehab were that there was a consistent local need for residential treatment (82%) and consistent levels of funding for rehab (63%).

The reasons given by the 14% of commissioners who reported decreasing numbers of people accessing rehab were that there was less local need for residential treatment (54%) and there was more and better community abstinence-based provision available locally (46%).

4. Other themes from the survey

4.1 Threat of closure

Related to both funding and occupancy, 60% of providers said they had felt the threat of closure in the past few years. Those providers identified a number of factors behind the threat, including falling referrals and occupancy levels, the related reduction in funding and the end of a ring-fenced supporting people grant funding to some services. Some providers stated that they had feared closure in the past, but referrals and occupancy have improved over recent years.

4.2 Other issues

Other issues raised in the survey were:

- providers noted that the clients they were treating had become increasingly complex in recent years
- providers expressed concerns about adequate staffing levels, training, salaries and recruitment
- a lack of move-on accommodation for clients leaving rehab was flagged up by several providers

Providers also raised a number of commissioning-related issues, including a view that some commissioners lacked understanding of residential rehab; that they are often “trying to get more for less money”; that commissioning systems are overly complex and

bureaucratic, and that commissioning via spot-purchasing created uncertainty compared to the financial security of block contracts.

5. Commissioning practice

The survey asked a number of questions about current commissioning practice. The general picture is that the majority of rehab placements are still spot-purchased on a case-by-case basis, from a wide range of providers that are mostly, if not all, away from the area where the client lives. Alternative methods such as using preferred providers lists, block contracts and residential treatment close to home are still only used in the minority of cases.

5.1 Use of preferred providers

The survey showed that about a third (35%) of commissioners use a preferred providers list to assist their commissioning of rehab placements. The most common ways of selecting preferred providers are via a tendering process (57%) and based on providers' outcomes (47%)

Most local authorities with a preferred providers list also spot-purchase placements in addition to the preferred provider, depending on the individual's need or preferences (71%).

Most of the local authorities that do not operate a preferred providers list make placements on a case-by-case basis (94%). Client choice was also an important factor for placements.

5.2 Use of block contracts

The survey found that 80% of commissioners do not use block contracts to commission residential rehabs. For the 20% who do use block contracts, economies of scale were the main reason, followed by consistency of treatment. For the bulk of commissioners who do not use block contracts, the main reason for not doing so is to give flexibility for clients to attend the rehab of their choice, as well as because the numbers of clients from their area entering rehab were too low to make it worthwhile.

5.3 Location of residential rehabs

Survey responses suggested that residential rehab is still mostly a national rather than a local resource. The vast majority of commissioners (79%) refer people out of their local area for rehab, and only 14% keep clients in their home area. Three quarters (72%) of providers agreed that their clients mostly came from outside their area.

The main reason for sending people out of area was because there was no local residential service (71%). About a third (32%) said they prefer to give clients more choice. Several commissioners added that clients normally want to leave their area to go to rehab.

For the few that did mainly commission rehab in-area, 80% said it was because they had good local residential rehab provision and 60% because their local rehab(s) have good links with community services and support networks.

6. Community rehabilitation and support

Residential rehab doesn't stand alone. We know from drug treatment data that most people who enter rehab have had a previous treatment in the community and many return to community services afterwards, either for further treatment or for post-rehab support.³

The survey revealed that in addition to the community treatment programmes most clients are in before entering residential treatment, specific rehab preparation programmes are available almost everywhere. After people return from rehab, there are a number of support mechanisms, the most common being mutual aid. There was also a reported increase in community-based abstinence programmes commissioned.

6.1 Rehab preparation

The survey asked commissioners whether clients were given preparation and support before going to residential rehab, because this is widely recognised as an important way to minimise early drop out. Almost all the commissioners (98%) reported that they provide rehab preparation and that it includes structured group work, rehab visits, support from keyworkers to work through hopes and fears, and sessions to explore what the client is likely to experience during the detox and rehab programmes.

6.2 Post-rehab support

The survey found that when people return to their home area after being away at residential rehab, there is a range of support available to help them sustain their recovery.

³ The role of residential rehab in an integrated treatment system (NTA, 2012)

Almost all commissioners (97%) said that there is access to local mutual aid groups, 80% said there is access to relapse prevention support programmes, and 63% reported access to a local recovery community.

In addition to these, over three quarters (77%) reported available support networks, including aftercare services, education, training and employment initiatives, recovery activities (such as involvement in local social enterprises such as recovery cafés), service user support groups, and housing support services.

6.3 Community-based alternatives to residential rehab

When asked about non-residential abstinence-based services, nearly three quarters (73%) of commissioners said they had structured day programmes. Two thirds (67%) also said they had other abstinence-based support available, including access to motivational programmes, group-based structured support including SMART recovery, dry houses, relapse prevention programmes, care planned one-to-one and group activities and a range of psychosocial interventions.

Over two thirds (70%) reported they had increased the amount of non-residential abstinence-based programmes they commission in recent years.

Of the 30% of commissioners who hadn't increased the amount of non-residential programmes they commission, the main reason was that they had good relationships with the residential rehabs they commission and some thought it was better for their clients to go to residential treatment.

7. Conclusions and future work

In the face of potential instability caused by commissioning changes, the picture of the state of residential rehab in 2013-14 painted by the commissioners and providers is broadly positive. In the first year of local authority responsibility for alcohol and drugs services, funding for rehab seems to have remained much the same, and over three quarters of rehab providers said they have either increased or maintained occupancy in the past few years.

The vast majority (85%) of local authorities responding to the survey said they have maintained or increased the numbers of people they sent to rehab over the past five years). Over half foresee their rehab spending remaining at similar levels to present, with only a third thinking it will decrease in the near future.

Despite a desire by many commissioners to maintain rehab spending and an expectation of growth by many rehab providers, the shadow of future budget reductions

remains and there is widespread concern from providers and commissioners about how this will impact on residential rehab services across the country. A third of commissioners think their rehab spending will decrease in future. The fact that 60% of providers have felt the threat of closure in the past few years may reflect wider concerns about funding throughout the sector, or perhaps reflect an ongoing concern typical of organisations with unpredictable cash flows.

The findings of this survey are broadly in line with the alcohol and drug review carried out by PHE and the Association of Directors of Public Health in early 2014. This review found that vast majority of local authorities (66%) indicated that funding levels were being maintained, with a further 28% describing uncertainty about future plans. However, a small proportion (6%) indicated that funding for rehab would reduce.

At present it is difficult to say whether the fears about funding will be realised, but the present variations seen across the country are likely to continue, partially because local authorities are responsible for assessing their own local need and commissioning to meet that need.

We know that outcomes vary across the residential sector⁴ but that the best performers help more than 60% of their residents go on to overcome dependence. However, all residential services will need to demonstrate value for money in the future as local authorities make savings and expect better outcomes from the services that they commission. Residential rehab providers may need to adapt to the changing marketplace they are operating in, with more flexibility and in the forging of better links with local treatment systems.

PHE will continue to support the need for local drug treatment systems to have good access to residential rehab. Many people with alcohol and drug problems need access to this type of treatment and these services have a good track record in helping people to recover from addiction.

PHE will carry out another residential rehab survey in early 2015 to see how the situation has changed a year on.

⁴ The role of residential rehab in an integrated treatment system (NTA, 2012)