

Residential Rehabilitation and the national drug strategy

A response to the government consultation
19th October 2007

In response to the Drug Strategy consultation, providers and organisations from across the field have been discussing the serious challenges faced by the residential rehabilitation sector.

There is a consensus on the seriousness and urgency of these problems and an urgent need to remove the structural obstacles to full integration of these services into the drug treatment system. The following signatories therefore strongly urge the government to take close account of the enclosed recommendations in the framing of the new drugs strategy.

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1. Executive Summary

- 1.1. The national drug strategy has achieved a great deal over the last ten years, most notably the doubling of capacity within the drug treatment system. This has taken considerable political 'will' and it is important that we recognise and celebrate the benefits of this investment. It is appropriate that the greatest area of growth has been within harm reduction oriented services and methadone maintenance.
- 1.2. Despite these achievements, the priorities and structures it put in place have created unforeseen problems for residential rehabilitation services. This form of treatment has been marginalised by the Drug Action Team (DAT) focused planning and funding mechanisms, leading to market stagnation, house closures and a drift toward under regulated residential provision.
- 1.3. A material portion of the residential sector is running at a deficit and not viable in the medium term. If houses close, the cost of entry to the market is so high that this capacity is unlikely to be replaced. The 'signal' given to the commissioning and planning fraternity by the content of the next drug strategy will be a critical factor influencing the future availability of this form of treatment.
- 1.4. An effective drug treatment system must be able to provide a range of services to meet the diverse needs presented by drug users. This includes interventions to reduce harm where drug users are unwilling or unable to become drug free and to support the ambitions of clients seeking to become abstinent. Residential rehabilitation is the most evidence-based treatment for clients seeking to become drug free.
- 1.5. This sector of the drug treatment system faces difficulties that threaten the ongoing availability of these services. See Appendix for narrative description of these challenges and further rationale for the solutions we propose.
- 1.6. In order to secure the future existence of these services it is our belief that the next drug strategy should:
 - **Set out a framework and timescale to create a regional commissioning structure to replace the current purchasing model.**
 - **Create incentives for the drug treatment system to promote opportunities for abstinence within and alongside a sustainable investment in harm reduction.**
 - **Clarify the regulatory framework for this form of treatment so that equivalent provision is subject to the same standards, inspection and oversight.**
- 1.7. The concern of this document is residential rehabilitation. Several of the signatory organisations also run non residential services and will also submit more general responses to the drug strategy. Although the consultation is concerned with drugs, the key issues and recommendations described here apply equally to residential rehabilitation for alcohol and we would urge government to keep mechanisms for drug and alcohol residential rehabilitation aligned.

Recommendation 1: Set out a framework and timescale to create a regional commissioning structure to replace the current purchasing model.

2. Summary

2.1. The single most important step is a move to a commissioning rather than purchasing based market, driven by a wide-scale rollout of a block contracting arrangements. This step would raise standards through closer performance management of services, stabilise the market and avoid the long-term loss of capacity resulting from occupancy fluctuations.

3. A structure to deliver quality

3.1. One of the biggest weaknesses of the *current* purchasing model is its inability to provide consistent and effective performance management of residential provision.

3.2. The purchaser provider split is in principle a good way to manage performance: commissioners act on behalf of clients and the public purse to monitor providers, who should feel pressure to meet the performance and quality targets.

3.3. Care managers are not able to performance manage residential services to a satisfactory standard. They rely to some degree on the regulatory framework provided by the Commission for Social Care Inspection (CSCI), which functions well to monitor basic standards (for registered houses) but provides little oversight of the quality or appropriateness of the treatment programme itself. Their contractual relationship is based around a handful of clients so their leverage is limited.

3.4. To drive quality, the current system relies on the abilities of care managers to generalise from their experience of individual clients to create demand side pressure that will then translate into improvements in quality and encourage the better providers to open new services. This is ineffective because purchasers and providers have poor market information and the supply side of the market is *highly* inelastic so new houses will not come on stream to replace 'failed' services.

3.5. By having a single commissioner for each service, an appropriate level of oversight becomes possible. Care managers would identify quality issues and pass these to the lead commissioner, who would then agree clear action plans agreed with the provider.

3.6. We should disentangle care management from commissioning. Care managers would continue to assess, support individual clients and feedback to commissioners. The commissioner would lead on the contractual and performance management relationship with the provider.

3.7. Commissioning should not be solely at the DAT level, as the purchasing power would not be sufficient to commission the full range of provision needed by the local population. The best approach appears to be a cluster or regionally based commissioning structure, with Local Authorities and DATs pooling most of their budget allocation for tier four (such a function would logically cover inpatient units as well) and participating in a 'joint commissioning' process.

4. A structure to deliver value for money

- 4.1. Funding for residential rehabilitation treatment is complex in the extreme.¹ This creates onerous and time-consuming administration for every admission; bringing increased risk of late payment, threatened cash flow and bad debts. The considerable expense and systemic inefficiency of this funding mechanism ultimately falls on commissioning budgets.
- 4.2. A commissioning rather than purchasing based model would reduce the number of contractual relationships, streamline paperwork, improve cash flow, reduce bad debt, assist financial planning and increase value for money. Most of all, occupancy fluctuations would not result in unplanned loss of capacity to the whole sector. Capacity could strategically managed, driven by appropriate assessment of need.
5. A structure to meet client need and deliver choice
- 5.1. A commissioning rather than a purchasing based market will enable a more rational allocation of resources. Commissioners are in a better position to undertake or review needs assessments and commission a portfolio of providers to meet identified needs. Each area should have a range of services within their contracted portfolio, including short and long stay treatment, smaller as well as larger houses and a range of therapeutic perspectives; reflecting the diversity of client needs, evidence of effectiveness and guidance within Models of Residential Rehabilitation.

Recommendation 2: Create incentives for the drug treatment system to promote opportunities for abstinence within and alongside a sustainable investment in harm reduction

6. Summary

- 6.1. The current drugs strategy provides little incentive for national and local planners to promote the treatment goal of abstinence, the outcome best achieved through residential rehabilitation. Further development of the drugs strategy should embed the validity and desirability of this treatment goal within treatment planning.

7. Shift in culture

- 7.1. A modest shift in emphasis within the national drugs strategy would be sufficient to overcome the 'poverty of ambition' within many harm reduction services that undermines the contribution of rehabilitation. The goal should be to ensure that all clients are periodically encouraged to consider the option of pursuing a goal of abstinence; and for the local drug treatment system to support clients to achieve this if it was their favoured goal.
- 7.2. This shift in emphasis needs to be driven by targets and reporting mechanisms. At first sight, the new PSA "The number of drug users recorded as being in effective treatment" lacks ambition – this indicator does not value the desired outcome of full recovery and rehabilitation for drug users.
- 7.3. Examined in more detail, we welcome, on balance, the inclusion of 'planned discharges' as an indicator. This high-level recognition of the importance of clients completing treatment should be included within Local Area Agreements as well as DAT plans.

¹ See first section of Appendix

7.4. This measure does appear, however, to be ambiguous. An NDTMS record of planned discharge from a *service*, is not a definitive indicator of treatment success and rehabilitation for the whole treatment *system*. If the intention is to monitor the performance of the whole treatment system, clients admitted to other services subsequent to the planned discharge should not be included in the count as they clearly have not succeeded in their treatment journey. This is an ambiguity within the PSA and needs clarification.

Recommendation 3: Clarify the regulatory framework for this form of treatment so that equivalent provision is subject to the same standards, inspection and oversight.

8. Summary

8.1. Not all services offering residential rehabilitation are subject to the same regulatory oversight, creating distortions in the market and increasing risks to clients. The strategy should seek a means to rectify this.

9. High standards of oversight across the sector

9.1. Most existing residential rehabilitation houses are registered as care homes with CSCI. If a provider sets up a *new* house they may, however, under the current drafting of guidance, choose not to register as a care home, thus placing the house outside the regulatory and inspection framework provided by CSCI. Some of these houses are also outside of the Supporting People Quality Assessment Framework.

9.2. Houses in this position may still market themselves as providing residential rehabilitation, though are under-regulated. In the absence of regulatory oversight, some of these houses have been able to compete on price by reducing staffing levels below CSCI requirements. This distorts the market and risks the safety of clients.

9.3. In the interests of both client safety and the stability of the market, there is a strong argument for all residential rehabilitation services to be registered with CSCI or be regulated via Supporting People.

10. Conclusion

10.1. The residential treatment sector is providing an excellent range of services that are being under-utilised to an extent that threatens to undermine the long-term success of the drugs strategy. The prospect of a new national drugs strategy presents an excellent opportunity to fix these serious problems and improve both the value for money of the treatment system and the outcomes for drug users and the communities within which they live.

Appendix 1 – Background analysis

The financial inefficiencies of the current system

The residential sector is under financial pressures that no other major area of drug treatment has faced.

The cost of residential rehabilitation has increased significantly above the rate of inflation for the last five years. The exceptional costs that have hit the field include the loss of large amounts of Supporting People money, costs of meeting care standards, above inflation increases in salary costs (with wage inflation driven by increased Pooled Treatment Budget (PTB) / Drug Intervention Programme (DIP) money and NHS settlements) and the occasionally staggering repair bills that come with maintaining large and aged buildings. Providers have had no choice but to pass on at least some of these costs to purchasers through increased prices.

The current purchasing model creates structural inefficiencies that damage value for money of this treatment modality. Providers quote a gross price to local authorities, but can only calculate the amount to invoice after the admission takes place. This calculation is itself based on the client making a fresh application to the Department of Work and Pensions, with all the delays and hours on the phone that this entails. Some funders refuse to sign an assurance they will pay the full amount if the benefits system for some reason fails to pay their share. Occasionally care managers sign funding agreements that council finance departments fail to honour even after the client has spent several months in treatment. The amount charged for a client can also change several times during an episode of care.

An inadequate commissioning framework

There are deeper structural problems that underlie and compound the difficulties with funding, foremost of which is the purchasing rather than commissioning approach to funding this form of treatment.

In a perfect market, rational consumers (purchasers) shift their patronage when they are unhappy with a particular product. The worst performing producers go out of business and new entrants to the market vie for business, driving down prices and pushing up quality.

The current arrangement of the residential rehabilitation 'market' is profoundly imperfect and will never match this ideal of classical economics: both purchasers and providers have poor market knowledge so are limited in their ability to act as rational consumers and providers; the costs of entry to the market are high and margins so low that new entrants do not set up new houses to replace those that close and different houses ostensibly providing a similar product are subject to different levels of regulation.

The behaviour of purchasers and providers can be understood in economic terms by looking at the incentive structure of the market. The incentive structure of the current purchasing model does not work in the interests of clients – perversely it is often in the purchasers' interests to minimise referrals, to make placements as short as possible, irrespective of client need, and not invest in communication infrastructure with providers.

The current purchasing model for the residential sector is arguably not 'fit for purpose'. Instead of driving down prices and pushing up quality, it damages the ability of providers to invest in their services and risks further reductions in the availability of services that will be difficult and expensive to replace in the future. A commissioning based model is clearly the solution to these problems.

Progress by the NTA and DoH

The DoH Tier Four capital grants programme in 2006/7 demonstrated that there was political will to support the residential sector. The grants were helpful to many organisations, in particular enabling providers to tackle major and long overdue repairs.

The NTA are aware of the pressures on the residential market. They have advocated a shift toward regional consortia based commissioning and have set out a clearer role for residential rehabilitation within DAT treatment plans. We understand that the NTA is also working with CSCI and the Healthcare Commission toward a more robust and relevant inspection regime. There has been an increase in block contracting, several regions thinking about regional coordination (if not commissioning) of T4 and evidence of a material increase in the use of pooled treatment money to fund residential rehabilitation. In the main, the documents such as Models of Residential Rehabilitation and the commissioning guidance for tier four services have been good.

There is some evidence of progress out in the field. There appears to be evidence of increased amounts of pooled treatment money being spent on residential rehab, which is very welcome. Some organisations reporting that their utilisation has begun to stabilise.

However, the NTA does not have a sufficiently clear steer from government on the status of abstinence as a treatment goal and appears not have the authority or leverage to make some of the critical changes that are required. In particular, the NTA is not in a position to close the problematic split in the financing of the drugs field between community care and the pooled treatment mechanism.

A Continuum of services to respond a spectrum of need

The primacy of crime reduction as a policy objective within the current drug strategy has had unintended consequences for the option of rehabilitation and full recovery from substance misuse within the drug treatment system.

In abbreviated form, the current drug strategy rests on the assertion that the 327k drug users dependent on class A drugs are responsible for a large proportion of acquisitive crime – and that drug treatment will greatly reduce this behaviour. For opiate users at least, it is assumed that the most cost effective way of reducing criminality amongst this group is Methadone Maintenance Therapy (MMT).

It is an important achievement that greater numbers of dependent opiate users than ever before have access to this evidence based form of treatment because of the current drug strategy. MMT (and indeed many other harm reduction interventions) has undoubtedly saved a large number of lives, has protected the health of thousands of drug users and made a substantial contribution to the safety of our communities. The next drug strategy should seek to maintain the availability of this and other harm reduction interventions.

The degree of lifestyle change achieved by clients on MMT is a worthwhile 'return on investment', for individual drug users and the whole community. What this treatment does not appear to do, however, is to provide a true exit from the interrelated behaviours, harms, risks and lifestyle norms associated with dependent drug use. Crime is reduced, health improved, illicit drug use reduced – but many clients could achieve so much more if they were drug free. In both quantitative and qualitative terms, MMT offers better life prospects than class A dependent drug use; it is *equally* true that abstinence offers better life prospects than MMT.

Describing severe dependency as a chronic relapsing condition has encouraged the medical profession to develop a more realistic and compassionate approach to treatment. It is, for example, increasingly rare to see prescribing clinics *enforcing* withdrawal of medication against the wishes of a client.

The flip side of this increased understanding of the *persistence* of addictive disorders is a cultural and structural *pessimism* about the possibility of recovery. The narrative of 'chronic and relapsing conditions' has obscured the possibility that drug users might recover and recover fully from their addiction – an eventuality that abundant research shows to be a common and 'naturally occurring' feature of dependency.

This lack of attention to the option of abstinence appears to be out of tune with the aspirations of clients'. In one survey, a clear majority cite abstinence as their only treatment goal and a full three quarters included abstinence along with other desired objectives

For clients who wish to pursue abstinence, the case for residential rehabilitation is very strong – taking one example of research, only 6.7% of clients on a methadone detoxification programme were abstinent 33 months after entering treatment, as opposed to 29.4% of those entering residential rehabilitation - and just 3.4% of those on MMT, (McKeganey et al).

As providers of both harm reduction as well as abstinence based services, we see clear need for the treatment system to include a range of services to respond to the spectrum of client need. This includes harm reduction services and long-term MMT. The clients of these services should, however, be periodically encouraged to *consider* abstinence as an option, as a desirable and achievable goal of their treatment. Harm reduction approaches should be framed to help clients step down the 'ladder of harm', but ever mindful that the bottom rung itself steps off into abstinence.

For those that choose it, residential rehabilitation offers a more fundamental shift in lifestyle, values and behaviour than is commonly achieved through other treatment methods. For successful clients, rehabilitation is the path to full integration or re-integration into society; with *all* the rewards, responsibilities and opportunities this affords. In order to continue to deliver high quality, efficient and responsive residential services we need a radical and speedy shift in the commissioning processes for tier four services.

The commissioning of residential provision is also not being adequately performance managed. From the top, Public Service Agreement (PSA) through the planning structure, the incentive provided by targets and reporting has not actively promoted the treatment outcomes best achieved through residential rehabilitation. There continues to be little incentive on DATs to commission lower tier services with a requirement to provide pathways out of the treatment system. There is also a continued lack of strategic coherence between the management of the pooled treatment budgets and the community care budget.

Consequences for providers

There appear to be many reasons for the difficulties facing residential rehabilitation; prices have clearly risen faster than community care budgets, there is greater competition from both tier 3 provision and un-regulated houses and these services have been neglected by the DAT focussed planning system.

In 2006, the NTA quoted figures suggesting a 5% fall over the previous year, with average occupancy reducing from 85% in the 04/05 year to 80% in 05/06. Working with these figures: A typical house that is budgeted to breakeven at 85% but only fills 80% will run a deficit of some £35k on the year. According to EATA, the average occupancy reduction in 04/05 was 7%, suggesting an average fall in income of around £70k per house over this two-year period.