MAKING REHAB WORK

FOR YOU, FOR FAMILIES, FOR COMMUNITIES, FOR SOCIETY... FOR ALL

Mapping the route to make specialist care for people with complex needs accessible

PHOENIX FUTURES

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OUR THANKS

This report sets out to make recommendations to ensure that the system in England that funds and delivers effective residential treatment for substance use enables access for all people that need it.

The authors want to thank the following contributors who have given their valuable to time to supporting this report;

- English Substance Misuse Commissioners Group
- Choices Group
- RGUK
- Collective Voice
- Office of Health Improvement and Disparities
- NHS Addictions Provider Alliance
- CGL - Lived Experience group

We'd like to especially thank FAVOR UK for their vital work in advocating for families who have lost family members to addiction and sharing stories of people's treatment and recovery journeys.

ENDORSEMENT FOR THIS REPORT

We were heartened by the collective will of commissioners, providers and those with Lived Experience to raise the profile of residential treatment, expand provision and ensure that it is easily accessible to all people who could benefit.

This report is supported by;

- ANA Treatment Centres
- Change Grow Live
- Choices Group

  The Choices group are a collective of independent UK Addiction Treatment Centres who came together in 2013 to share and influence best practice and inform policy makers.
- Collective Voice
- FAVOR UK
- Forward
- Humankind
- Kaleidoscope
- NHS Addictions Provider Alliance
- Noreen Oliver

  Director of The BAC (Burton Addiction Centre) and Director CSJ (Centre for Social Justice) - On behalf of The Trustees of The O'Connor Gateway Charitable Trust
- RGUK
- Turning Point
- WDP
- We Are With You

EXEC SUMMARY

MAKING REHAB WORK

The report has been commissioned by Phoenix Futures and carried out by Mike Pattinson and Kevin Crowley, two experts with many years' experience in the drug and alcohol treatment sector.

The findings have been influenced by people who use a wide range of treatment services, those with lived experience of residential treatment, commissioners and providers of residential and community-based treatment.

The report has wide ranging endorsement from across the drug and alcohol treatment sector.

We believe this is an important report. The causes for the decline in access to residential treatment are complicated, encompassing multiple factors which have changed over time. Addressing funding levels, and the way that treatment is commissioned, are essential actions. However, to improve access to residential treatment in England will require commitment from all stakeholders including local government, commissioners, Office for Health Improvement and Disparities, providers and others. We will all need to collaborate to develop improved approaches across the sector.

The full range of evidence-based services should be available for people in need wherever they live. This report does not advocate for one treatment approach instead of another. We need appropriately funded community-based treatment and improved access to residential treatment.

The people who will benefit from Making Rehab Work are amongst the most highly stigmatised in society. They are people who face prejudice on a daily basis that hinders their progress in life. They are brothers and sisters, sons and daughters, mums and dads. Often the discrimination they face started when then they were very young and has lasted a lifetime. This can change. Making Rehab Work is vital work and will provide a lifeline to the people with complex and multiple needs.

Key findings

Residential treatment is an evidence-based intervention which is effective in terms of treatment and cost.

Residential treatment is delivered to a higher standard than ever before. It enables people with more complex needs to recover and lead happy and healthy lives.

But fewer and fewer people are able to access it.

The report finds that the system that enables access isn't working.

Thousands more people every year should be benefiting from life-saving residential treatment.

The report highlights the dramatic decline in access to rehab over the last 10 years and provides recommendations make rehab work for everyone.

Recommendations

1. We need renewed focus on the place of Residential Rehabilitation provision at a local commissioning level: with clear spending plans for committed resources (PH grant allocations, Universal Grant, RSI investment etc).

   We recognise this will require collaboration across the sector including local government, commissioners, OHID, providers and others, in order to develop improved approaches across the sector

2. We need to ensure that commissioning at a local level complies with national guidelines and that outcomes across the whole treatment population are effectively tracked. That there are effective and compliant processes in place for aftercare pathways.

   This will also require collaboration across the sector including local government, commissioners, OHID, providers and others, in order to develop improved approaches across the sector.

3. We need to ensure that those with Lived Experience are integral to the review of eligibility criteria, referral pathways and communication plans.

4. We need to refresh pathways between Inpatient Detox and Residential Rehabilitation – exploring the regional cluster approach of Inpatient Detox as a model that can be applied here.

5. We need a national specification for Residential Rehabilitation – building on NICE guidelines - to unpack eligibility criteria, quality standards, outcome monitoring and resettlement/aftercare provision. The work underway by the English Substance Use Commissioning Group in concert with providers and lived experience group can form the backbone of this.

6. We should establish supra-local authority commissioning arrangements for Residential Rehabilitation services, ring fencing budget allocation and administering provision outside existing local structures. Whether this is national, regional or ICS level commissioning should be worked through by a collaboration of ESUCG, Providers and Lived Experience Groups

7. We must ensure that preserving Residential Rehabilitation is part of a planned response to the Dame Carol Black review and is embedded in the work of the national recovery board, national recovery champion and critically, the National Outcomes Framework

8. We must ensure that a whole systems view of treatment is addressed by the CQC when they are conducting inspections. They should also inspect for what isn't there under 'effective' and 'responsive' KLOEs.

9. We should focus on the development of specialist provision (mental health, physical healthcare, culturally relevant, justice pathways or interventions for homeless people etc) to ensure provision meets existing and emerging needs re equity of access and parity of esteem.

MAKING REHAB WORK

HOW DO WE ENSURE THAT THE SYSTEM IN ENGLAND THAT FUNDS AND DELIVERS EFFECTIVE RESIDENTIAL TREATMENT FOR SUBSTANCE USE ENABLES ACCESS FOR ALL PEOPLE THAT NEED IT?

Karen Biggs
Chief Executive
Phoenix Futures

For more than 50 years Phoenix have provided residential treatment to people who find it difficult to get the help they need from other services.

Our expertise at Phoenix is in psychosocial interventions and we deliver those services in a range of settings to people who are using drugs and alcohol, on prescribed medication and abstinent. We know that people need a full range of treatment options delivered in line with clinical guidance to have the best chance to find treatment that works for them.

Residential treatment has been, and continues to be, an effective policy response to a wide range of social issues. But most importantly, residential treatment is a place of safety for some of the most traumatised and socially deprived people in society.

When people cannot find safety and security where they live, residential treatment offers them that place of safety, structure, and mix of interventions to build a better life away from imminent danger and risk.

However, in England it has become increasingly difficult, and even impossible in some regions, to access this specialist life-saving treatment unless you can afford to pay for it privately. People in greatest need and at greatest risk aren't getting the support they need. People who need the enhanced safety, security, and support offered by residential treatment are being failed.

Residential treatment is a NICE approved treatment and features as part of the UK Drug treatment clinical guidelines. It should therefore be available as a treatment for people with more complex needs in all regions of England. However, it is not.

Currently fewer than 2,000 of the approx. 270,000 people in treatment for substance use in England have been able to access residential treatment. That is 0.8% of the treatment system.

In 2010/11 more than 4,000 of the 200,000 people in treatment for substance use in England were able to access residential treatment, 2% of the treatment system.

Compared to the European average of 11%.

The numbers of people in community-based treatment have increased. The residential treatment sector is more highly regulated and effective at treatment delivery than ever, in terms of outcomes and cost. We might therefore have expected the numbers and percentage of people accessing residential treatment to increase. And yet;

- **Providers** tell us that after years of funding cuts their primary focus is on survival.
- **Funders** of residential treatment tell us they need help to justify why someone should get the funding for this specialist form of treatment
- **People seeking treatment** too often tell us that even though they had approached a number of professionals for support no one told them residential treatment was an option for them. Others tell us the process to access residential treatment is inaccessible, focused on funding rather than need, and traumatising.

Clearly the system for delivering residential treatment is not working to reach, engage and support those in most need. With access to residential treatment at a record low, and drug and alcohol harms at a record high, this is an issue we can't ignore.

The Dame Carol Black review of Drug Treatment published earlier this year made recommendations to increase the 'uptake and provision of residential and inpatient detoxification treatment'. It sets out expectations to increase residential placements incrementally with an additional 610 additional people benefitting from residential treatment in year 1 to an additional 5,700 people in year 5.

This review doesn't address blocks in the pathway to inpatient detox, but we do recognise the essential work of the NHS Substance Misuse Provider Alliance in improving access to, and supply, of detox services.

I commissioned this **piece of work to bring greater clarity to the problem faced by people seeking residential treatment** and to support the sector to make the improvements required to be able to realise the goals set out in the Dame Carol Black Review.

I commissioned an independent consultancy with many years' experience in the substance use treatment world, to speak with providers, funders, and people with lived experience of services.

Mike and Kevin consulted widely, and we are grateful to all who gave up their time to input and steer this work and the collaborative approach taken by Substance Misuse Commissioners. We believe this is the most in-depth consultation on residential treatment for many years.

Whilst Phoenix Futures commissioned this piece of work it was undertaken on behalf of a collaboration of residential treatment providers including the Choices Group.

We are grateful to Mike and Kevin, who have worked diligently and tactfully with the treatment system and with wider political and commissioning stakeholders to reach their conclusions.

There is much we as a treatment sector can do to improve access to residential treatment and I very much hope that this piece of work has helped to highlight those actions and focus our minds.

However, time and time again we heard that the commissioning system doesn't work for residential treatment, it wastes time and resources, is impossible to navigate for most and denies access to healthcare. All the things we want our commissioning processes not to do.

THE QUESTION WE SET OUT TO ANSWER WAS SIMPLY;

> "How do we provide good quality specialist residential treatment, that is free at the point of access, for people who are deemed within clinical guidance to benefit from it?"

THE ANSWER;

As the recommendations in this report highlight there are a number of actions we can and should take as a sector, but crucial we must have in place:

A. Additional ringfenced funding and;
B. A commissioning process that is fit for purpose for this specialist healthcare provision

Making change in these two crucial areas will provide the foundation for change and we are reassured that so many people share our commitment to realise the change that is needed.

MAKING REHAB WORK

A REPORT BY MIKE PATTINSON AND KEVIN CROWLEY

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1. INTRODUCTION FROM MIKE PATTINSON AND KEVIN CROWLEY

In preparing this report we entered the work with an open mind and a determination to listen and truly understand the current system. We employed a range of insight gathering techniques and a mix of methodological approaches.

We carried out a thorough literature review (cited and referenced throughout) and reviewed national and provider data compiled by Phoenix Futures the Choices group of Residential Rehabilitation providers.

We also used structured qualitative approaches through focus groups and individual meetings with NHS and Third Sector Community Providers, Residential and In-Patient Providers, Commissioners, PHE/OHID and the National Lived Experience Group of a large community treatment provider. We augmented the lived experience voice with case studies from across the sector. The conclusions and recommendations have been replayed and refined through feedback loops to stakeholders to verify their accuracy.

Residential Rehabilitation is a cornerstone of the UK drug and alcohol treatment system. Almost without exception the people we spoke to, be they commissioners, civil servants, people in treatment or providers, were enthusiastic about Residential Rehabilitation, its overall effectiveness and the positive role it played within a mature treatment system – particularly for those with 'complex needs'.

Throughout this document we have referred to published evidence of effectiveness and value for money of Residential Rehabilitation services. Residential rehabilitation is a NICE approved treatment endorsed by UK drug treatment guidelines.
It has also become clear that there is further work to do for the sector to evidence its effectiveness and for community providers and commissioners to recognise Residential Rehabilitation as a core element of a healthy treatment system. Nationally there is work to be done in terms of system-wide analysis of performance, impact and outcomes. We have, where appropriate, drawn parallels with the experience in Scotland in terms of co-ordination of, investment into and resourcing of Residential Rehabilitation.

We heard concerns expressed about: pathways, equity of access, funding, variable standards, waiting times and some myths persisting from outdated views about the Residential Rehab sector. This piece of work was commissioned to address these systemic issues. We have made a number of recommendations at the end of this report based upon everything we have heard, read and learned.

2. DEFINING RESIDENTIAL REHABILITATION: WHAT IS IT?

Residential Rehab is in a curious time and place – years of austerity and cuts to Local Authority budgets have contributed to a significant reduction of the number of providers of Residential Rehab services.

We have seen a rise in the number of alternative models that are trying to fill the gaps be they: enhanced supported housing, "dayhabs", quasi-residential or short stay privately operated residential units. These all undoubtedly have a place in the treatment landscape – but they are not Residential Rehabilitation services as covered by this report.

For the purposes of this report we are describing the traditional Residential Rehabilitation sector. We have put our own quality standard within the definition: they need to be registered and regulated by the Care Quality Commission and provide intensive interventions and care services with structured leaving care processes in a care home environment.

NICE Guidance Quality Standard 10 defines Residential Rehabilitation as:

"Residential rehabilitative treatment provides a safe environment, a daily structure, multiple interventions and can support recovery in some people with drug use disorders who have not benefitted from other treatment options. For people with drug use disorders to make an informed choice about residential rehabilitative treatment, taking into account personal preferences, it is important they are aware of the NICE eligibility criteria."

Within this sector there are a range of different models of Residential Rehabilitation. Most operate a mixed approach.

The following descriptions are currently published on the Rehab Online website:

12 Step

This is an increasingly broad term stemming from the 12 steps of the Minnesota Model and is associated with the approaches of Narcotics/ Alcoholics Anonymous (NA/AA). Residents will often spend time in "step" groups, in addition to other individual and group therapeutic activities.

Therapeutic Community

In a therapeutic community, staff and clients participate together as members of a social and learning community. Time will be spent in therapeutic group work, one-to-one keywork sessions, developing practical skills and interests, education and training.

Christian Philosophy/Faith-Based

Faith-based services have religious staff and may or may not require residents to share their faith or participate in faith-related activities. These activities will include; time studying religious texts and the lessons to be learned from them, in discussion and in prayer.

Eclectic/Integrated

These are programmes which do not adhere to a particular philosophy and use a range of different methods and interventions focused on meeting the needs of individual residents.

Cognitive-Behavioural Therapy (CBT) And Social Learning

These are programmes that include psychological treatments such as CBT, in which actions are believed to influence future behaviour.

Personal And Skills Development

The programme in a service operating a personal or skills development model may focus less on psychological therapeutic interventions and more on the practical skills and knowledge needed to get by in the wider community.

Most modern Rehab units adopt an eclectic approach to meeting residents needs within a primary philosophical framework. All residents can expect to have been appropriately assessed, working within an agreed care planned approach and should expect a robust aftercare / resettlement plan to support their return to their local community.

The following the features are typical of residential treatment in England;

- Comprehensive individual needs and risk assessment and support planning.
- Harm reduction advice and information.
- Psychosocial interventions, including but not limited to motivational and treatment engagement tools to reduce substance misuse, prevent relapse, and cope with cravings, these may be provided through a combination of one-to-one work and structured group work.

- Support to people who use services to understand the role of substance use in their lives, and the effect on themselves and their carers/families/friends.
- Specialist structured counselling for issues that may be related to substance use i.e. physical and sexual abuse, eating disorders, domestic abuse, offending, post-traumatic stress disorder.
- Regular key working with an identified key worker.
- Developing skills to maintain abstinence from illicit drugs and alcohol, including building coping skills and defence mechanisms and identifying and developing 'recovery capital'.
- Peer support mechanisms.
- Advice and information about Mutual Aid and recovery networks, and support that facilitates access to Mutual Aid meetings.
- Support to understand the key factors in maintaining behaviour change.
- Provision and/or promotion of literacy support and access to education and training.
- Support to develop improved social, relationship and living skills.
- Relationship counselling.
- Support with housing and resettlement.
- Support to develop independent living skills.
- Relapse prevention planning and support.
- Engagement with community-based support services in the area of planned residence following the placement.
- Physical and mental health screening.
- Wellbeing support including help with smoking cessation.
- Complementary and/or sports therapies.
- Advice and information for carers and family members who will offer support and help post-discharge.
- Family support services and/or family therapy where appropriate.
- Support for people using the service with learning disabilities/physical disabilities.
- Where appropriate, the Provider will encourage carers and families to be involved in the support offered and will recognise the positive role that they can play in recovery.

“My family are now back in my life - I love speaking to my daughter and son on the phone. I am now able to see my mum and sisters’ again, seeing the relief their eyes when they see me is amazing. They have peace of mind, they are sleeping again at night instead of being up worrying about me. They are able to continue with their lives now with their son/ brother back in their lives.”

-Dave

3. DOES IT WORK? THE EVIDENCE BASE

There is an established evidence base which is almost 'taken as read' within the sector.

The relatively positive impact of Residential Rehabilitation has been analysed in numerous studies and publications including: DTORS, NTORS, DORIS, DWP 2015, EMCDDA.

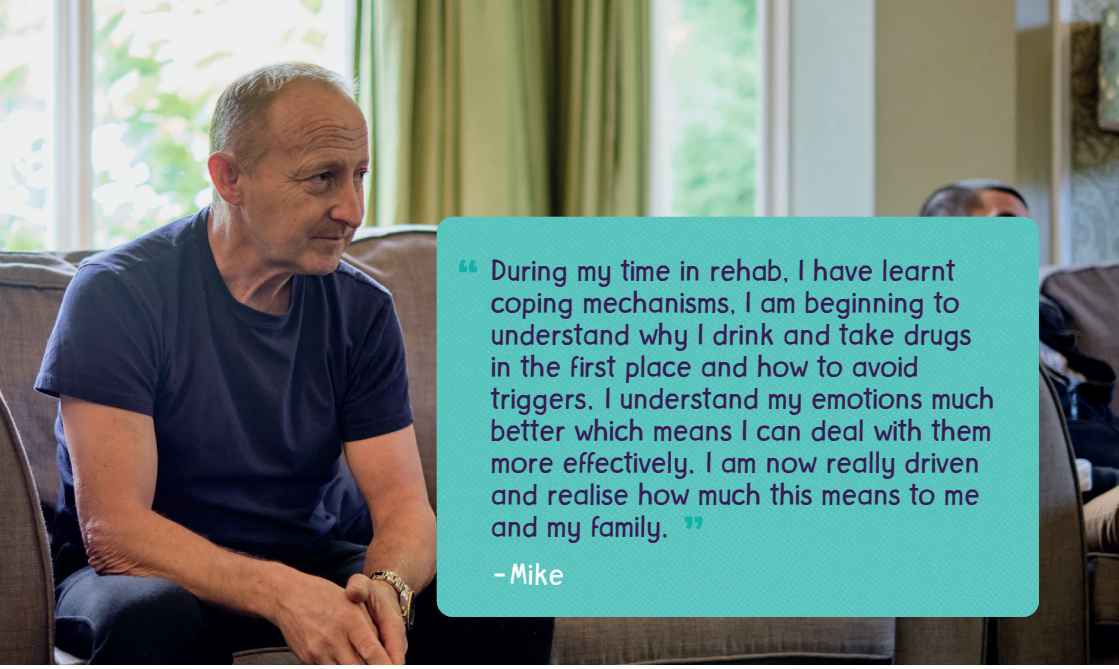
All of these studies have concluded to differing degrees (and often against differing metrics) that Residential Rehabilitation works. It provides value for money. It reduces individual and societal harms. It provides sustainable recovery.

Moreover, Residential Rehabilitation for substance misuse is a NICE recommended intervention and has been through the technology appraisal process – so should be mandatory part of any treatment system. This is particularly so for people using services with co-morbidities or who have not thrived in community settings.

It is worth remembering that people using services are significantly more likely to leave the treatment system as a whole having been through on residential rehab pathways.

There are some encouraging data points on effectiveness including:

- Over 2/3rds of people in residential rehabilitation complete their treatment journeys there. (NDTMS 2021 and provider data)
- Rehab resident's Health and Wellbeing improves by 66% during their time in RR (Provider TOPs scores)
- Rehab resident's Mental Health improves by 79% during their time in RR (TOPs scores)
- Rehab resident's Physical Health improves by 44% during their time in RR (TOPs scores)
- Rehab resident's Quality of Life improves by 69% during their time in RR (TOPs scores).



Quality and Governance

This is a robustly governed sector with clear regulation and inspection regimes. The sector has lost some 40% of providers over the last 10 years – and it is accurate to say that those that have survived have tended to be the most resilient, respected and effective ones.

- 100% of state funded rehabs are rated by CQC as Good or Outstanding.
- Choices Group and many provider national frameworks exclude those not meeting these standards.

The system knows what ‘good’ Rehabilitation is:

Residential Rehabilitation is a well-established treatment intervention, it has been extensively evaluated, is NICE recommended and has an established set of quality criteria. Residential Rehabilitation in this context is an enhanced care pathway rather than an alternative. The system therefore knows what ‘good is’ which can be broadly summarised as:

- 90 days absolute minimum (NTORS 2001)
- The longer the treatment duration the better the outcomes (DTORS&DORIS, EMCDDA 2020)
- Evidence based approaches and interventions (EMCDDA 2020)
- Community reintegration while on the programme (NTA/CQC 2007)

- Significantly better outcomes when inpatient detoxification is followed up with residential treatment. Ghodse et al. (2002)
- Easily accessed and wrap around concerns taken care of (EMCDDA 2020/McKay 2009)
- Continuity of care following residential treatment (McKay, 2009, NICE Standard QS9).

> "Residential rehab provided a safe space for Client A to start to address underlying trauma. Alongside group therapy, we delivered 1-2-1 counselling, and in cases of certain traumas, EMDR. Many of the women we support have complex PTSD as a result of multiple traumas experienced across many years. The safety afforded by a highly supportive residential setting enabled client A women to start this process."
>
> -Rehab Provider

But, how well does it work?

It is clear that clients treated via Residential Rehabilitation do 'better' than those within community treatment services. In addition to the published evidence base our research has shown that outcomes for Residential Rehabilitation are 83% better than community treatment for a more complex cohort. (NDTMS TOPS vs Provider Data) Also,

- Residential Rehabilitation 'Successful Completions' have improved for every drug group every year over the past 3 years (+8%) as community completions have deteriorated (-2%).
- People who use rehab services are 3 times more likely to complete their whole treatment journey in residential treatment settings. (NDTMS 19% SC&NR across all community drug groups vs <60% for residential rehabilitation) (DWP research 2015)
- Justice Outcomes (drug related offending savings) are 100% better for people in treatment who undertake residential treatment. (DWP research 2015)
- Rehab residents make 83% greater gains across health, mental health and quality of life than community services (NDTMS TOPS vs Provider Data).

> “I visited a few rehabs but (this one) felt like home, I felt secure and I felt relaxed, which is so important when starting something new. I had the wrong perception of rehab... but to my surprise I have actually loved every minute. It’s an experience I will never forget.”
>
> -Steve

Is it value for money?

It is often held that Residential Rehabilitation is not cost effective when compared to other lower threshold forms of treatment. We reject this argument and there are clear indications that when compared to other forms of enhanced treatment for health conditions that it represents clear value for money. The complexities of funding arrangements devolved into and distributed at a local level however cloud this judgement.

The authors contend that the focus of current assessment and selection processes in fact favours ‘cost control’ over a systematic view of clinical need – in ways that we do not see in any other specialist health care sector. The evidence review and current clinical guidelines overwhelmingly support an expansion of Residential Rehabilitation as an integral element of a modern treatment system.

The outstanding argument is about by ‘how much’ and does the additional cost of Residential Rehabilitation justify the investment when compared to other forms of less resource intensive treatment.

We would again point to the evidence base that;

- Successful completions from the whole treatment system are three times more likely from Residential Rehabilitation (NDTMS vs provider data) (DWP 2015)
- Each successful completion in Residential Rehabilitation provides net savings of £43,904 per year (WMPCC & ANA SIB research)
- The outcomes for those completing an Inpatient Detoxification are significantly more successful when it is followed by a period or Residential Rehabilitation. (Ghodse et al 2002)

4. WHO IS IT GOOD FOR? THE PEOPLE WHO BENEFIT THE MOST FROM RESIDENTIAL TREATMENT

Those with complex health and social care problems

The evidence base and clinical guidelines are clear that Residential Rehab is the prescription for complexity. Those with co-morbid physical and mental health or other complex problems are primarily indicated for residential pathways (NICE 2007). On this then, it is worth remembering that;

- Successful completions are 3 times better for people with highly complex needs in residential rehabilitation (DWP research 2015)
- Mental health for people in Residential Rehabilitation starts off worse but ends up better than community average with 60% greater gains on average (NDTMS TOPS vs Provider Data)
- Physical health for people in Residential Rehabilitation starts off worse but ends up better than community average with 83% greater gains on average (NDTMS TOPS vs Provider Data).

> "Following an attempt on my life when I woke up in a hospital with my mum and sister by my side, I finally accepted help and realised that I couldn't do it alone. I was fast tracked to rehab - it felt right and now it's my spiritual home. My family are now back in my life - I love speaking to my daughter and son on the phone. I am now able to see my mum and sisters' again, seeing the relief their eyes when they see me is amazing."
>
> -David

People with long-term problematic use of substances

Residential Rehabilitation as a 'high cost – low volume' intervention is also traditionally reserved for those for whom previous community treatment interventions have proven 'unsuccessful'.

We know that for many of these client groups their engagement in the treatment system is likely to end upon successful completion of Residential Rehabilitation.

They recover and stay well. Through this lens for many people Residential Rehabilitation becomes a 'finishing school' for treatment systems. (NICE 2007)

But, we must also be mindful of the evidence and NICE guideline that where appropriately targeted those 'new' to treatment record longer term gains when exposed to Residential Rehabilitation. (NTORS, DTORS)

People from racially minoritised communities

Our own research has shown that people from Black, Asian and Minoritised Ethnic communities are underrepresented in residential rehab vs community treatment (7% vs 11%*) but when people are able to access Residential Rehabilitation treatment outcomes are as good as, if not better than, non B.A.M.E groups** (NDTMS*) (Provider data**). We contend that existing funding, assessment and referral processes therefore unfairly limit access to treatment for these groups – even if this is at an unconscious level.

*Aggregate RR provider data

Outcome	FY 2018-19	FY 2019-20	FY 2020-21	Grand Total	BAME 3 yr avg.
Treatment / Programme Complete	63%	66%	71%	66%	67%
Incomplete	28%	25%	25%	29%	29%
Transferred	9%	9%	5%	5%	3%
Grand Total	100%	100%	100%	100%	100%

Women

Women do better in residential treatment versus community settings (Provider data).

Outcome	FY 2018-19	FY 2019-20	FY 2020-21	Grand Total	Female 3 yr avg.
Treatment / Programme Complete	63%	66%	71%	66%	69%
Incomplete	28%	25%	25%	29%	26%
Transferred	9%	9%	5%	5%	3%
Grand Total	100%	100%	100%	100%	100%

> “My next steps include getting my daughter back home. I want to start to volunteer with the elderly as during the height of my drinking I was very isolated and it was a horrible feeling. As such I want to help the elderly who many of are very isolated. I want to get my health back on track and start taking my dog for long walks. Rehab has given me hope to build on my motivation and live without alcohol.”
>
> - Alison

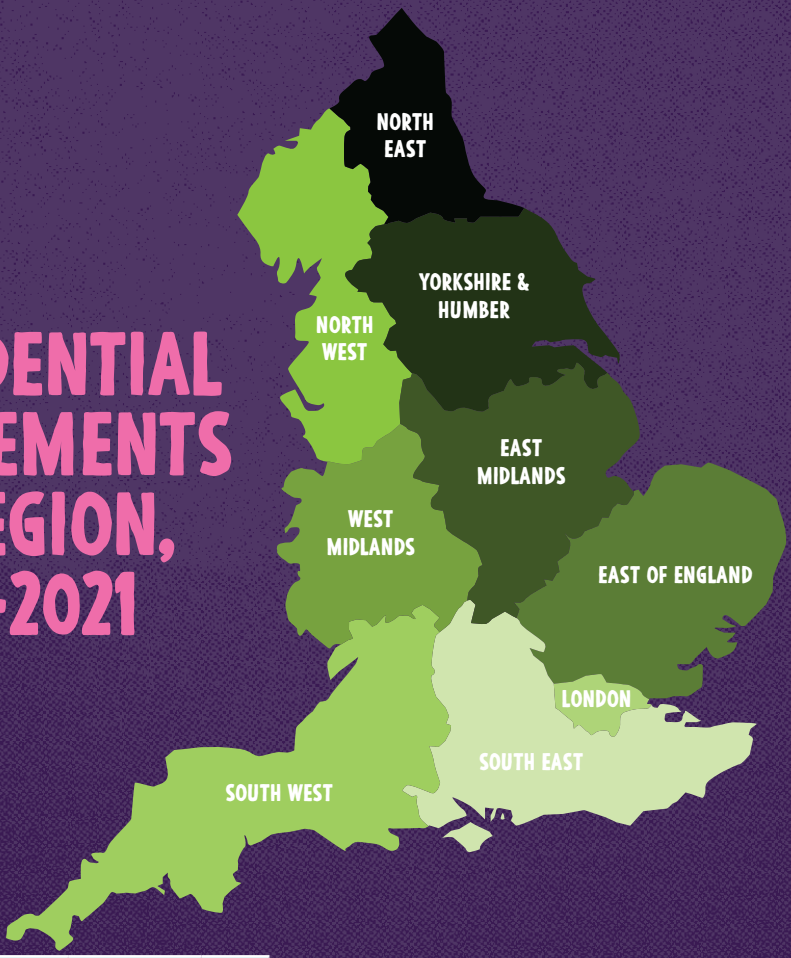
5. HOW IS RESIDENTIAL REHAB BEING USED? THE CURRENT BLOCKS TO EQUAL ACCESS

Despite this evidence of effectiveness, NICE endorsement and long-established funding and assessment and referral processes, Residential Rehabilitation is an under-utilised resource. Placements in Residential Rehabilitation have fallen by circa 15% year on year for the last 6 years.

In 2020-21 less than 1% of the treatment population in England and Wales received Residential Rehabilitation as an intervention. The European average is 11% (EMCDDA) This figure is even more alarming when seen alongside deteriorating outcomes within community services and significant unspent funds through central Government programmes like the 2020 Rough Sleeper Initiative ring-fenced funds for Residential Rehabilitation.

- Sector-wide occupancy rates are between 70-80%
- On a single day in October 2021 there were 190 vacancies showing on the Rehab Online booking site.
- There are an estimated 600 unused places per annum in current treatment system generating £25m net loss to society (WMPCC ANA stats)
- Full universal grant Residential Rehabilitation funding is not used (PHE)
- There are effectively rehab deserts – North-East of England 7 areas with no access and as a region only 19 placements made within a treatment population of some 20,000 people
- Residents of the South-East of England are 13 times more likely to access Residential Rehabilitation than those from the North-East.

RESIDENTIAL PLACEMENTS BY REGION, 2020-2021



Region	Proportion of rehab	Key
North East	0.10%	
Yorkshire & the Humber	0.39%	
East Midlands	0.54%	
East of England	0.55%	
West Midlands	0.70%	
North West	0.96%	
South West	1.07%	
London	1.12%	
South East	1.28%	

The map shows the levels of rehab placements across England. The figures are shown as number of new rehab placements as % of treatment population.

Source: NDTMS Report Viewer (Adult Activity Report - Partnership; 2020-21)

MYTHS EXAMINED AND DISPELLED

Through our work on this project we encountered some of the old myths about Residential Rehab and we thought it useful to spend some time invoking and dispelling these.

"Rehab is too expensive"

Residential rehab together with inpatient detoxification facilities are the most intensive form of addiction treatment for people with high needs and at high risk. It is of course costly but not when compared with other residential treatment facilities and modalities. Apart from the clear value for money argument outlined above, there is a moral issue in saying that a NICE recommended treatment is too expensive. We cannot find another example in healthcare where commissioners have determined that a NICE approved treatment is too expensive.

"Rehab is unregulated and ungoverned"

This is possibly the easiest myth to dispel and yet it persists in general discourse about Rehab. By definition we are talking about CQC registered and CQC inspected services – all of which have received a good or outstanding rating. Quality rehab is subject to the same regulatory regime as community treatment providers and providers are proud of this status.

"There isn't the demand for rehab"

While it is true that in various postcodes and commissioning areas across the UK, residential treatment is de facto unavailable, this is not a 'demand side' issue. We have listed the various barriers and funding restrictions within referral systems, but it has amazed us that people who use rehab services and their families report navigating these hurdles and wait in inhuman uncertainty for a space to be funded. Providers report meeting people who have been trying to access this form of treatment for years and families who take out loans to pay for private treatment for their loved ones. The lack of demand is a fallacy.

"Funding isn't the answer"

This is a difficult one to understand and yet it persists. We agree that just putting more money in isn't the answer but the evidence from the Black Review is clear that there is systemic underfunding of the whole sector and a decimation of Rehab in particular. The planned re-funding of the whole system needs to apply to all treatments and especially the NICE recommended treatment for people with complex needs and poor community outcomes.

"We would need immediate capital investment to increase access"

Again, this is factually inaccurate. As shown elsewhere there is a systemic vacancy rate across the estate of approximately 200 beds per night. With no new capital costs, we could give 600 people per year an evidence-based shot at life.

"People are left vulnerable when they leave residential treatment"

This is another curious myth and as with most myths rooted in a grain of truth. While it is true that risk of lapse and overdose are increased as someone leaves treatment, prison or rehab, this is not an argument for not funding it. Access to drug treatment is the primary predictor in lower mortality rates and if anything, this is a call to arms to properly fund onward pathways and aftercare. The latter is also a NICE quality standard so again should not be negotiable.

ACTUAL, NOT MYTHICAL BARRIERS

We spent a significant amount of time getting under the systemic issues inhibiting the utilisation of Residential Rehab and there was considerable agreement on what is wrong.

Funding Residential Rehabilitation treatment – a curious anomaly for a NICE endorsed treatment

To understand how we arrived at the situation where a CQC regulated, NICE endorsed health intervention is simply not available in certain areas, an understanding is needed of how anomalous the funding of our sector actually is. The Public Health grant, unlike most healthcare funding, is devolved to local authorities is ringfenced for specific purposes and is very much finite in nature. Unlike mainstream health, where CCG money can be moved between funding demands and between years, this is a sealed system with no release valves. The various compromises, efficiencies and trade-offs needed to commission a whole treatment system within an inflexible budget leads many commissioners to tightly ration, curtail, or simply not fund residential rehabilitation. While the pressures to cut costs are understandable, that a recommended treatment for the most complex and at-risk people is simply not available in certain areas, is not.

Funding… this is not a myth. There simply isn't enough funding getting through to support existing provision.

There has been a disproportionate decline in funding for Residential Rehabilitation vs Community Treatment - by 40% since 2015-16.

Postcode lottery

This was a widespread issue in both data and qualitative feedback with not only regional variation but contiguous commissioning areas with hugely varying provision, eligibility and waiting times.

- Both supply and demand side of residential treatment pathways are under pressure
- With only a small number of notable exceptions referrals into Residential Rehabilitation services are down across the country in 2020-21 despite the increased availability of funds and spare capacity within the sector.

- Residential Rehabilitation provision is not equally distributed around the country. These disparities become even more stark if one considers the distance from treatment facilities with 'Rehab deserts' across regions.
- 'People won't want to travel for treatment' was cited by providers but this was emphatically refuted by the groups of people who use rehab services that we spoke with
- An alternate rationale from providers was that a negative feedback loop develops with less and less resource being put into residential pathways for more and more challenging people, who do not do so well in treatment, until eventually there isn't the resource to fund local residential projects.

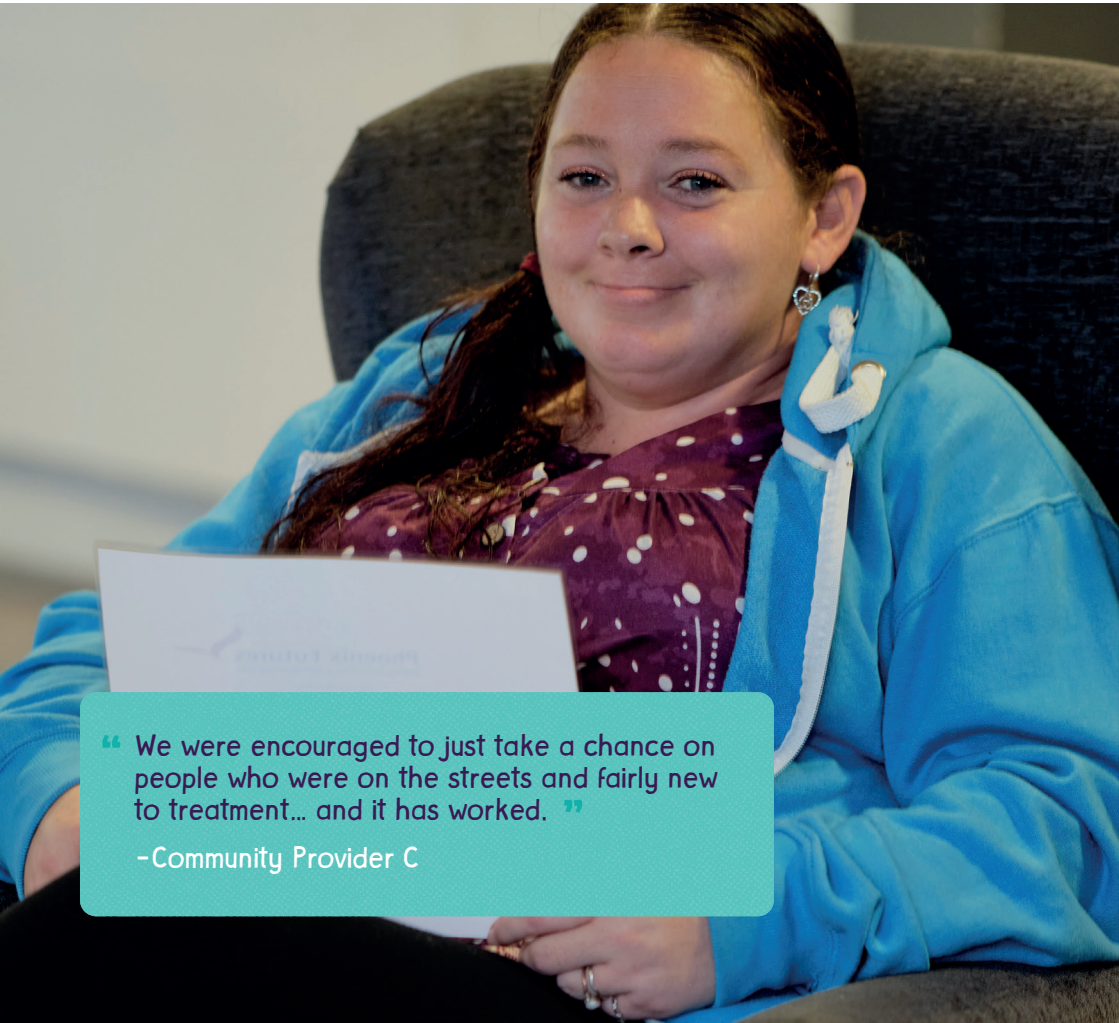
Commissioning structures do not support Residential treatment as a high cost / low volume activity

- Budgets and funding decisions are localised – whereas residential rehabilitation provision covers a wide (possibly national) community group
- There is considerable inconsistency in the way funds are controlled and administered at a local level – sometimes held within the LA itself, other times delegated as part of community treatment provider allocations, sometimes ring-fenced and sometimes not
- Community providers can report what they have spent on Residential Rehabilitation – but lose 'control' of the data once care is transferred so cannot report on how many people have been successfully placed or what happened to them next.
- No single specification for what Residential Rehabilitation should provide and no shared eligibility criteria
- Adult Social Care involvement where it exists is focused on gatekeeping the money and tends to add complexity instead of support
- Frameworks and Panels – the lack of standardised specifications and eligibility criteria has contributed to an ever more complicated landscape that both providers and people within the treatment system have to navigate. Providers report having to apply to be on multiple framework agreements without any guarantee of referrals being made. People report long waits for funding decisions and incomprehensible assessment processes.

System fragmentation

Because Residential Rehabilitation providers are neither viewed as core components of local treatment ecosystems and are not in control of their profile and relationships at a local level, they are in some sense outsiders in these systems. This results inevitably in communication breakdowns – so community providers and commissioners express concerns about waiting times while residential providers carry vacancies. Similarly, there was a lack of clarity about service availability during the Covid pandemic.

We saw some great examples of what can happen when Residential Rehabilitation units were utilised as a "Rehab First" response to homelessness through the 'Everyone In' initiative in places like Liverpool and Leeds.



> "We were encouraged to just take a chance on people who were on the streets and fairly new to treatment... and it has worked."
>
> -Community Provider C

Preparation

Uncertainty about funding means poor preparedness from community providers. A fragmented system leads to a lack of clarity about who should remain in contact with the rehab resident, often compounding their sense of vulnerability and isolation.

Welfare Benefits

Fear of losing benefits appears to be more an issue than actually losing them. However, contributions to social care funding can be an inhibitor, as people who use residential treatment are expected to contribute approximately 10% of the treatment cost themselves. Accessing Housing Benefit is also an issue for Housing Benefit supported provision. Scotland allows dual funding for this purpose whereas England does not.

Complexity of need

Despite the recognition that Residential Rehab was the prescription for complexity, there was consensus that this was true up to a point. There was a nervousness about the appropriateness of capability of the sector to work with those with the most complex needs whether they be young people, those with dual diagnoses or those with entrenched histories of rough sleeping. All community providers saw this as an opportunity to develop specialist provision.

Detox pathway

Inpatient provision leading to Residential Rehab is a geographical challenge despite the evidence base (Ghodse 2002). NHS Provider Alliance colleagues describe a significant reduction in the funding and availability of in-patient detox facilities and the uncoupling of the pathway from in-patient to residential rehabilitation.

Workforce awareness

It is clear that some community providers are not fully aware of Residential Rehabilitation provision or eligibility criteria so are not promoting it. This despite the promotion of Rehab being a NICE quality standard.

Aftercare pathways

Although a core NICE quality commissioning standard (Nice 2009) are often experienced as an afterthought. This is due to the complexity of negotiating and phasing multiple forms of support provided by different agencies.

6. HOW CAN WE IMPROVE ACCESS? WHAT NEEDS TO CHANGE – CONCLUSION AND RECOMMENDATIONS

What we heard, read and learned in developing this report demonstrated time and time again the value which Residential Rehabilitation retains within the treatment ecosystem.

We were heartened by the collective will of commissioners, providers and those with Lived Experience to raise its profile, expand provision and ensure that all people who can potentially benefit from rehab have exposure to it.

Funding of course remains the biggest single inhibitor – Residential Rehabilitation is at face value the most expensive interventions within the system. However, the evidence of value for money is now even more compelling.

We contend that the current approach of locally devolved funding arrangements, inconsistent referral pathways, opaque eligibility criteria, variable quality standards and the lack of central oversight of outcomes and impact does not work.

Where Residential Rehabilitation services are geographically dispersed the current localisation of assessment and funding is simply unfit for purpose. It excludes people from accessing healthcare, it leads to financial losses for the provider sector, it fails to meet emerging needs around complexity and damages families and communities on health and economic grounds.

We fully support the ambitions of the Dame Carol Black Review and the desire to expand Residential Rehabilitation by a further 5,700 places per annum. After a five-year period, this would raise the proportion of the treatment population in Residential provision to circa 5% of the total – a five-fold increase but still only half the European average.

Within this expanded sector the ability to use system wide data analysis through NDTMS becomes an even more important issue to resolve.

It also fails to learn from current models of good practice that we have seen during and arguably resulting from the pandemic including:

- A move towards ring fenced national funding of Residential Rehabilitation placements in Scotland
- The approaches taken in areas like Leeds and Liverpool where “residential rehabilitation first” was seen as an effective response to the Everyone In initiative.

We have presented these recommendations as simply as we can. Having started with an open mind on this issue and value of Residential Rehabilitation we are now convinced that the costs of not making these changes are simply too high.

1. We need renewed focus on the place of Residential Rehabilitation provision at a local commissioning level: with clear spending plans for committed resources (PH grant allocations, Universal Grant, RSI investment etc). We recognise this will require collaboration across the sector including local government, commissioners, OHID, providers and others, in order to develop improved approaches across the sector.
2. We need to ensure that commissioning at a local level complies with national guidelines and that outcomes across the whole treatment population are effectively tracked. That there are effective and compliant processes in place for aftercare pathways. This will also require commitment for all stakeholder to collaborate including local government, commissioners, OHID, providers and others, in order to develop improved approaches across the sector.
3. We need to ensure that those with Lived Experience are integral to the review of eligibility criteria, referral pathways and communication plans.
4. We need to refresh pathways between Inpatient Detox and Residential Rehabilitation – exploring the regional cluster approach of Inpatient Detox as a model that can be applied here.

5. We need a national specification for Residential Rehabilitation – building on NICE guidelines - to unpack eligibility criteria, quality standards, outcome monitoring and resettlement/aftercare provision. The work underway by the English Substance Use Commissioning Group in concert with providers and lived experience group can form the backbone of this.

6. We should establish supra-local authority commissioning arrangements for Residential Rehabilitation services, ring fencing budget allocation and administering provision outside existing local structures. Whether this is national, regional or ICS level commissioning should be worked through by a collaboration of ESUCG, Providers and Lived Experience Groups

7. We must ensure that preserving Residential Rehabilitation is part of a planned response to the Dame Carol Black review and is embedded in the work of the national recovery board, national recovery champion and critically, the National Outcomes Framework

8. We must ensure that a whole systems view of treatment is addressed by the CQC when they are conducting inspections. They should also inspect for what isn't there under 'effective' and 'responsive' KLOEs.

9. We should focus on the development of specialist provision (mental health, physical healthcare, culturally relevant, justice pathways or interventions for homeless people etc) to ensure provision meets existing and emerging needs re equity of access and parity of esteem.

> “I had no idea there was a life without drink and drugs but now I can talk to people, have real belly laughs, maintain eye contact, look in the mirror and feel the sun on my back. Being in rehab has taught me forgiveness, I can't change the decisions I made in the past but I can be the best version of me now.”
>
> -Laura

Appendix 1: Full reference list here

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Appendix 2 TOPS scores vs Community Average

Quality of life 3 year average

Service	Initial Score	Final Score	% Change
Provider A	7	16	130%
Provider B	9	15.7	73%
Provider C	10.3	16.3	59%
Provider D	8.6	16.2	88%
Provider E	9.57	15.62	63%
Residential Rehab Average	8.9	16	79%
National Average	10.8	14.9	38%

Physical Health 3 year average

Service	Initial Score	Final Score	% Change
Provider A	9.2	14.7	60%
Provider B	10.9	15.3	40%
Provider C	11.4	15.6	37%
Provider D	9.8	14.7	50%
Provider E	10.9	14.8	36%
Residential Rehab Average	10.5	15	44%
National Average	11.7	14.5	24%

Psychological Health 3 year average

Service	Initial Score	Final Score	% Change
Provider A	6.7	15.4	130%
Provider B	9	15.1	69%
Provider C	10.5	15.6	49%
Provider D	9.6	15.4	60%
Provider E	9.8	14.8	51%
Residential Rehab Average	9.1	15.3	68%
National Average	10.2	14.5	42%

All TOPS scores 3 year average

Service	Initial Score	Final Score	% Change
Provider A	7.6	15.4	102%
Provider B	9.7	15.4	59%
Provider C	10.7	15.9	48%
Provider D	9.4	15.4	65%
Provider E	10.1	15.1	49%
Residential Rehab Average	9.5	15.4	63%
National Average	10.9	14.6	34%