

“Drug treatment comes in a variety of forms and settings. The popular notion of a spell in rehab, beloved of the tabloids, is not representative of mainstream treatment and recovery services provided in England. The reality is more complex...”

THE ROLE OF RESIDENTIAL REHAB IN AN INTEGRATED TREATMENT SYSTEM

The role of residential rehab in an integrated drug treatment system

FOREWORD

“The right residential rehabilitation placement for the right individual at the right time can be a powerful and cost-effective step on their journey to recovery from drug addiction.

“A period in residential rehab functions best as an integrated part of a local treatment system. Success should be judged by how many individuals go on to complete treatment and sustain their recovery, not just by how many people leave residential rehab having completed one segment of their journey.

“The analysis reported here identifies troubling discrepancies in performance between residential rehab providers. The best take some of the most challenging individuals in the treatment system, retain a high proportion for the duration of the programme, and then provide planned, supported integration into the community – often involving referral to community-based services.

“Other providers, however, have high drop-out rates, low levels of programme completion, and even lower levels of subsequent discharge from the treatment system. Surprisingly, differential performance does not seem to be related to the complexity of the client population or the cost of a placement.

“The NTA will be working with the sector to understand the factors underpinning good performance, and engage those providers who are currently under-serving their clientele in a process of improvement. Transparency of provider-level data will enable commissioners and service users to make more informed choices about residential placement.

“At the same time, we will challenge the small minority of local partnerships who inappropriately restrict access to residential places for their treatment population, in order to make this potentially powerful element of treatment genuinely accessible to all.”

Paul Hayes
NTA Chief Executive

EXECUTIVE SUMMARY

- 1** Residential rehab is an integral part of any drug treatment system, a vital option for some people requiring treatment for drug dependence. Anyone who needs it should have easy access to rehab, whether close to home or further away.
- 2** Many different types of residential rehab are available. The most common factor is that residents have to stay overnight to receive treatment, and are expected to be abstinent before they start the programme.
- 3** Residential rehab currently accounts for 2% of people in adult drug treatment but 10% of central funding. On average a period in rehab costs £600 a week, making it much more expensive than non-residential treatment services.
- 4** An audit of annual data returns shows that residential rehab is not an automatic exit door from the treatment system, but an integral part of a network of services. Three-quarters of residents come from community-based treatment services before accessing residential rehab, and the majority return for further structured support afterwards.
- 5** For every ten people who go to rehab each year, three successfully overcome their dependency, one drops out, and six go on to further structured support in the community. Of those six, two overcome dependency with the help of a community provider, at least two are still in the system, and at least one drops out.
- 6** Almost two-thirds of those who drop out from residential rehab do so in the first few weeks, suggesting that referring services and receiving facilities need to ensure people are better prepared before entering residential programmes and better supported during their stay.
- 7** Outcomes vary across the residential sector. The best performers see more than 60% of their residents go on to overcome dependence, while the poorest struggle to enable 20% or fewer to overcome addiction. All services will have to demonstrate value for money in an increasingly outcomes-focused healthcare landscape.
- 8** The best-performing rehabs do well with complex users, who often do not benefit from cheaper community treatment. To justify the extra cost of residential placement, rehabs will in future have to focus on the complex cases, where they can add value to the treatment system.
- 9** Rehabs are more successful at retaining and treating residents with severe alcohol dependency than drug addicts – possibly because dependent drinkers have more personal and social capital to invest in recovery.
- 10** In the light of the 2010 Drug Strategy, the NTA is collaborating with the Recovery Partnership and others to help residential rehab providers adapt to the shift to an outcome-focused local public health system in which they are paid by results. Some providers will need to improve their performance in order to meet the future needs of commissioners and service users.

“There is a wide range of residential rehabilitation available, and services differ widely in terms of their philosophy, intensity, content and duration”

Introduction

Drug treatment comes in a variety of forms and settings. The popular notion of a spell in rehab, beloved of the tabloids, is not representative of mainstream treatment and recovery services provided in England by the NHS and voluntary sector. The reality is more complex.

Residential rehab is a vital option for some people requiring treatment for drug dependency. Anyone who needs it should have easy access to rehab, whether close to home or further away.

However, most people receiving specialist treatment for drug problems won't need to access residential facilities. They can have their needs suitably met by community drug treatment services, which have increased in availability and effectiveness in recent years.

There are around 100 rehabs in England that are regularly commissioned by public authorities, and over 4,000 users who were in treatment during 2010-11 accessed them as part of their treatment pathway. Yet this is only a fraction of the overall picture of drug treatment in England.

To put it in context, there are about 1,200 NHS and voluntary sector community services treating around 200,000 adult patients every year. Every local authority has a dedicated mechanism for assessing the need for drug treatment, and accessing a range of specialist interventions, of which residential services are one aspect.

Like other parts of the public sector, the drug treatment system is under increasing pressure to demonstrate that it offers value for taxpayers' money. The government's 2010 Drug Strategy challenged commissioners to do more to promote recovery, and put providers on notice that they would increasingly be paid by outcomes for their public sector contracts.¹

In the light of these developments the NTA has been working closely with the residential sector, through the Recovery Partnership, to help prepare providers for forthcoming changes to the public health commissioning framework and to help them find their appropriate market in a time of change.²

This report builds on that collaboration, using previously unpublished data from the National Drug Treatment Monitoring System (NDTMS) to describe the important contribution that residential rehabilitation makes to the drug treatment system in England. It also highlights the successful outcomes achieved

by the best providers, and acts as a baseline for an ongoing programme of partnership with the sector to further improve the provision and commissioning of services.

Character, costs and commissioning of residential rehab

Residential rehab services are run by voluntary and private sector organisations. They offer structured programmes that may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills.

There is a wide range of different types of residential rehabilitation available, and services differ widely in terms of their philosophy, intensity, inclusion criteria, programme content and duration. Often the only common factors among this variety of providers are that residents have to stay overnight at the facility to receive treatment, and they are expected to be drug and alcohol free before they start the programme.

Traditionally, residential rehabs have been located in large houses in the countryside or by the coast, away from the inner city areas where many users became addicted. This pattern is changing as providers respond to new thinking – and market opportunities – by offering alternative urban arrangements, based around housing support. These innovative developments, combining local accommodation and an off-site treatment programme, are sometimes called 'quasi-residential' services.

Although the residential setting is shifting, the traditional commitment to abstinence remains a fundamental tenet for most rehab providers. This puts the onus on individuals to be motivated to be drug-free before they undertake a programme.

In some cases detoxification is offered by the rehabs themselves as the first stage of the treatment; otherwise people who need detox would be referred to NHS in-patient services beforehand.

In 2010-11, commissioners planned to spend about £42m on residential rehab, according to local drug treatment plans. Although residential rehab only accounts for 2% of treatment activity in terms of user numbers, the additional cost means it accounts for 10% of central community treatment funding.³

Commissioning treatment has always been a local responsibility, with decisions made using local intelligence based on local need. However, the mechanism by which this process is undertaken is changing as a result of the government's healthcare reforms.

“This shifting healthcare landscape offers an opportunity to develop even more integrated commissioning of residential rehab at local level”

Until now, health authorities, local councils, police and probation services have shared joint commissioning arrangements for drug treatment. Although some residential places are purchased within these arrangements using the central government's mainstream drug treatment budget, local authority community care budgets fund most residential provision.

In some areas there has been a lack of integration between the locally commissioned treatment system and local authority-led arrangements for residential rehab, leading to fragmented care pathways.

From April 2013, local authorities will take on responsibility for commissioning all drug and alcohol treatment services as part of their new role in improving the public health of their populations. They will receive a dedicated public health grant, from which they will be expected to commission drug and alcohol treatment services according to local need. New Health & Wellbeing Boards will provide strategic oversight of the commissioning process.

This shifting healthcare landscape offers an opportunity to develop even more integrated commissioning of residential rehab at local level. In particular, local authorities could choose to align the historic community care funding – usually available for residential treatment – with the local drug and alcohol component of the new public health grant.

Costs and clinical effectiveness of residential rehab

When the National Institute for Clinical Excellence (NICE) reviewed the evidence for drug treatment services in 2007, it recommended that residential rehab should be used for the most complex users.⁴

Although NICE made clear that community services should be the frontline treatment option for most drug-dependent people, it recognised the particular role rehab could play for those seeking abstinence who had significant co-morbid physical, mental health or social problems.

The NICE appraisals balanced cost-effectiveness with clinical effectiveness, and were reflected in the 2007 UK Clinical Guidelines (known as the Orange Book), which guide practitioners on how to provide treatment for drug misuse and dependence.

Of all the treatment types and settings available, residential rehab is at the expensive end of the spectrum. Prices vary according to provider, but the average cost of a week in rehab is around £600.

Since the average time spent in residential rehab is 13 weeks, commissioners spend on average £8,000 for every episode they commission. This makes residential rehab notably more expensive than a comparable period of treatment in a community setting.⁵

The residential rehab data audit

NICE called for more research into the outcomes for individuals whose treatment pathways include a residential component. One of the frustrations of the residential sector in recent years has been that little progress has been made on that front.

The NTA is now coordinating a national collaborative study to explore the effectiveness of residential treatment in order to identify the groups of service users for whom residential rehab is particularly effective. The aim of the study is to develop the evidence base further and better inform commissioners about the types of people who are likely to benefit from residential services.

Meanwhile, NDTMS offers a valuable source of material on how treatment works in practice. Now one of the most comprehensive datasets in the NHS, it collects detailed information from individual users, providers and commissioners to build an unrivalled picture of the drug treatment system as a whole.

During the course of the recent engagement between the NTA, Recovery Partnership and representatives of the residential sector, it was acknowledged that differential reporting to NDTMS by residential rehabs meant that it was not possible to robustly judge the cost-effectiveness of individual providers. Consequently an audit of rehab returns to NDTMS was undertaken early in 2012, an analysis of which is included in this report.⁶ All these figures were independently verified by the National Drug Evidence Centre at Manchester University.

There are slight variations on the official drug treatment statistics published in October 2011, which were based on a dataset that was ‘frozen’ in July 2011.⁷ For example, the audit counted 4,166 rehab residents in 2010-11, compared to the 4,232 in the annual statistical report. However, this variation is not statistically significant and has not made any substantial difference to the conclusions drawn from the exercise.

One issue emerging from the audit was that a significant proportion of people were identified as receiving continued structured support in other parts of the treatment system after they had finished a treatment programme in a rehab.

“Rehab is not always an ‘exit door’ from the treatment system. People frequently require continued support from other parts of the system”

In some cases, people were being transferred to another provider or referred on for further treatment. In other cases, however, they were reported as successfully completing treatment at the residential rehab but then recorded as continuing treatment in other parts of the system.

The NDTMS definition of completing successful treatment is being judged by a clinician to have overcome dependency on the substance for which the user is admitted to treatment, and no longer having a structured treatment need. The definition was intended to capture people when they were ready to exit the system, not necessarily when they left a provider within it.

The audit has enabled NDTMS to clarify its procedures for collecting future data from rehab providers. Also, from October it will collect more detailed information about treatment settings and types, and the time spent there. This will enable providers to record where residents have successfully completed a programme but been referred to another provider for further support.

Meanwhile, the timing of the rehab audit, in early 2012, meant the NTA could track the progress of the 4,166 rehab residents beyond the year-end, and investigate what happened to them in 2011-12 as well.

This extra material provides a unique insight into the treatment journey of an entire cohort, and enables us to provide for the first time a detailed breakdown of the longer-term outcomes to which residential rehab contributed.

Summary of the residential rehab data

The findings clearly demonstrate how residential rehab is an integrated part of the network of services that form local treatment systems.

The data also shows that rehab is not always an ‘exit door’ from the treatment system, and that when people complete their treatment at the residential rehab they frequently require continued structured support from other parts of the system before they are ready to complete their treatment for drug or alcohol dependency.

The audit found 4,166 individuals in drug treatment in 2010-11 had residential rehab as part of their latest treatment pathway. Three-quarters of them (76%) had treatment in community services before accessing residential rehab.

Leaving aside the few (194) who were recorded as still in residential rehab at the end of March 2012, the outcomes for the remaining 3,972 people are illustrated in figure 1.

The left-hand side of the diagram lists their discharge status as reported by the residential rehab providers in 2010-11 under three categories. The chart then maps what happened to these individuals by the end of March 2012.

Of those recorded as finishing a rehab programme:

- 1,110 (28%) left the treatment system directly from residential rehab, having overcome their dependency and having no further structured treatment need. They therefore met the NDTMS definition of successfully completing treatment
- 898 (23%) finished a residential programme to the satisfaction of the rehab provider, but were then recorded by another community-based provider as continuing in treatment elsewhere in the system
- of the 898, approximately half (475) went on to overcome their dependency and leave the system successfully following their period with a community provider
- a further 144 spent time with a community provider but then dropped out. The remaining 279 were still in treatment in the community at March 2012.

The progress of individuals recorded as either transferred or dropped out can be tracked in a similar manner. In both categories, it can be seen that many of those people who left residential rehabs went on to have further contact with community providers, and a proportion of those successfully completed treatment and overcame dependency from those alternative routes.

This raises a question over how to measure the contribution that residential rehab makes to the drug treatment system as a whole. On the one hand, 1,110 people successfully completed treatment direct from a rehab (28%). On the other hand, a number of other residential rehab residents also successfully completed treatment, but only after receiving further structured support elsewhere (14%).

This latter category would include not only the 475, illustrated in figure 1, who overcame dependency after a period with a community provider, but also 76 rehab residents who were officially recorded as being transferred to another provider.

“Individuals move between community and residential settings, with both sets of providers playing a significant and mutually-reinforcing role in their recovery”

However, it would exclude the small number (219) who went on to overcome dependency despite dropping out of rehab.

As with treating any chronic condition, recovery from drug and alcohol addiction carries an ever-present risk of relapse. The audit found that one in five of those rehab residents who successfully completed treatment came back for more specialist help within six months. However, there was no difference in the re-presentation rate between those who left straight from the residential rehab, and those who went on to have further support from community treatment providers.

These findings demonstrate the fluidity of the treatment system in operation, and the difficulty comparing different parts of it. However, they do enable us to draw some general conclusions.

Broadly speaking, the data tells us that for every ten drug users who were in treatment that year and accessed residential rehab on their treatment journey:

- three successfully overcame their dependency directly from the residential rehab
- one dropped out of treatment altogether
- the remaining six received further structured support from the treatment system.

Of those six:

- two went on to complete their treatment with a community provider and overcome their dependency that way
- at least two are still in the treatment system (so their outcomes have not yet been realised)
- at least one dropped out at a later stage.

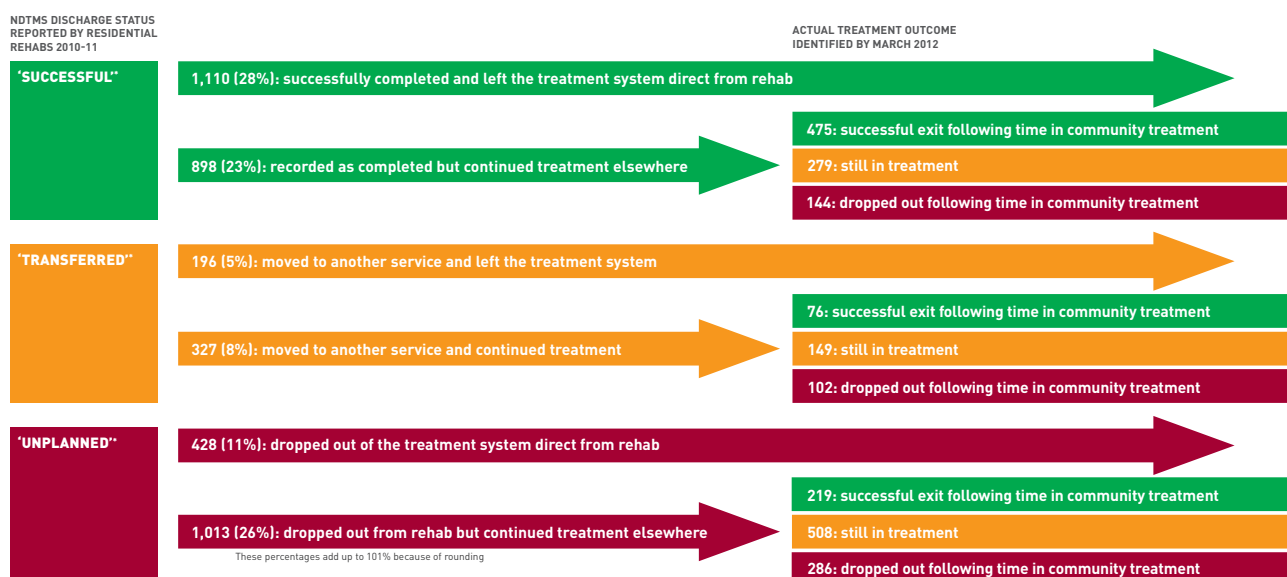
The audit therefore paints a picture of an integrated treatment system in which individuals move between community and residential settings, with both sets of providers playing a significant and mutually-reinforcing role in their recovery.

Dropping out of residential rehab

One other noteworthy aspect of the data findings is the rate of unplanned exits from residential rehab. Just over one-third of the original cohort of 2010-11 residents was recorded as dropping out by the rehab provider.

Of the 1,441 individuals who left in an unplanned way (36% of all residents), some will have declined to proceed with a treatment programme and a minority may have had their treatment withdrawn. The data shows that 428 (11%) left the rehab and were straightaway lost to the treatment system altogether.

1. THE TREATMENT JOURNEYS OF 3,972 RESIDENTIAL REHAB RESIDENTS, 2010-12



* 'Successful' means completed a rehab programme; 'transferred' means moved to another service; and 'unplanned' means dropped-out

“The high level of early drop-out highlights the importance of effective preparation and robust engagement on the part of community services and receiving providers”

However, the remaining 1,013 (26%) stayed in the system and continued to access treatment elsewhere in the community. A small number (219) went on to overcome their drug dependency through this route. This confirms how residential and community services work together in an integrated system, responding collaboratively to the needs of people who leave rehab prematurely.

Nevertheless, in the light of this finding, we examined the discharge data in more detail to break down the point at which people left prematurely. Figure 2 shows that almost half of all drop-outs from rehab occur in the first two weeks of the programme, and more than 60% occur within a month.

Where an individual declines treatment this also tends to happen quite quickly, whereas the point at which a provider withdraws treatment occurs pretty much evenly during the duration of the residential programme.

Some individual providers have higher rates of drop-out than others. Nevertheless, all in the residential sector have a responsibility to ensure the best outcomes for their clients.

The high level of early drop-out overall suggests that a significant proportion of those put forward for residential rehab may not be

ready to undertake such an intensive programme. This highlights the importance of effective preparation and robust engagement on the part of the community services referring people on to rehab and the receiving providers.

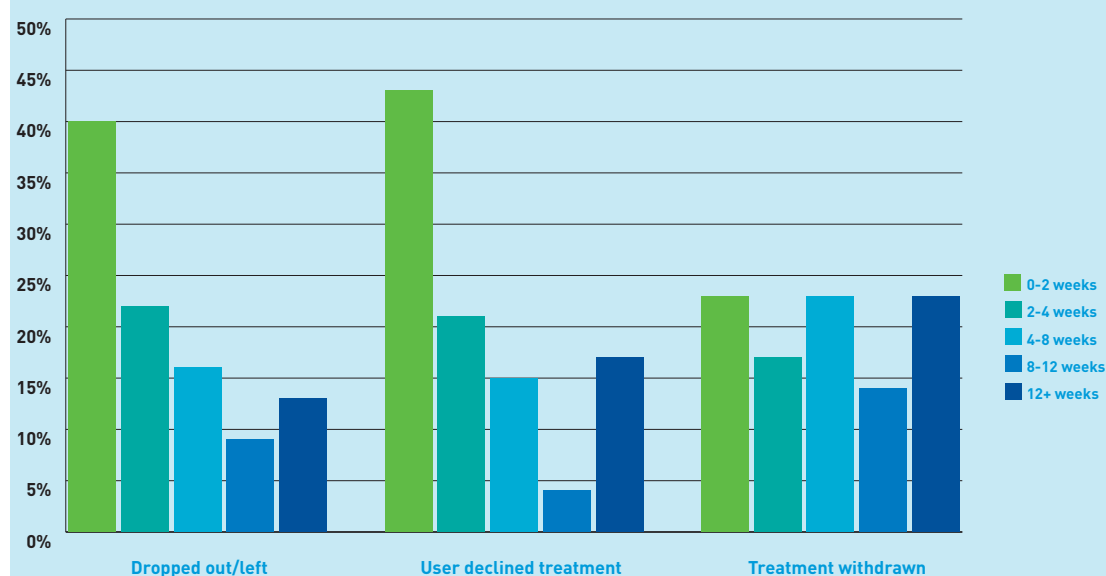
Do residential rehabs treat more difficult clients?

The drug treatment population as a whole is a challenging one, and unplanned discharges are common across the system. The high rate of drop-out reported by residential services is likely to be because they treat some of the most complex drug users, in line with NICE recommendations. People accessing residential rehab will usually have:

- failed in community treatment more than once
- longer and more entrenched drug and alcohol misusing careers
- a range of problem substances
- more significant housing problems
- poorer physical and psychological health

NDTMS data shows that residential rehab services tend to see proportionately more presentations from people who use heroin and crack (the most problematic addicts) than do other treatment services in the community (fig.3). Residential rehab clients are also more likely to be injecting, involved in poly drug use, or offenders.

2. Time in contact with the residential provider before exit



“If residential rehab providers can demonstrate clinical and cost effectiveness, their services will continue to be purchased from public funds”

All this means that users attending residential rehab are likely to be more complex, in terms of their chances of achieving a successful outcome compared to the system as a whole. They are particularly liable to have higher numbers of previous unplanned episodes of treatment than users in other parts of the system.

Having said that, people accessing rehab will also usually be:

- abstinent from drugs and alcohol following detox
- committed to becoming substance free and wanting to leave treatment
- assessed as capable of achieving abstinence and prepared to do so.

Although it is clear that residential rehabs tend to see people with more difficulties, they do not usually admit highly problematic users until a certain amount of preparation has already happened in the community. Often local authorities will not agree to fund people who they believe are not ready for rehab.

In future, it seems likely that residential rehabs will need to focus even more on this complex-user group. Community treatment has become more accessible and delivered better outcomes over the past decade. With their budgets under pressure, commissioners may be increasingly choosing to treat people in

cheaper community services which are often as effective as the more expensive residential option.

However, there remains a core of complex drug users for whom community treatment isn't working, and it is likely be with these people that residential rehabs can really add value in helping them towards recovery.

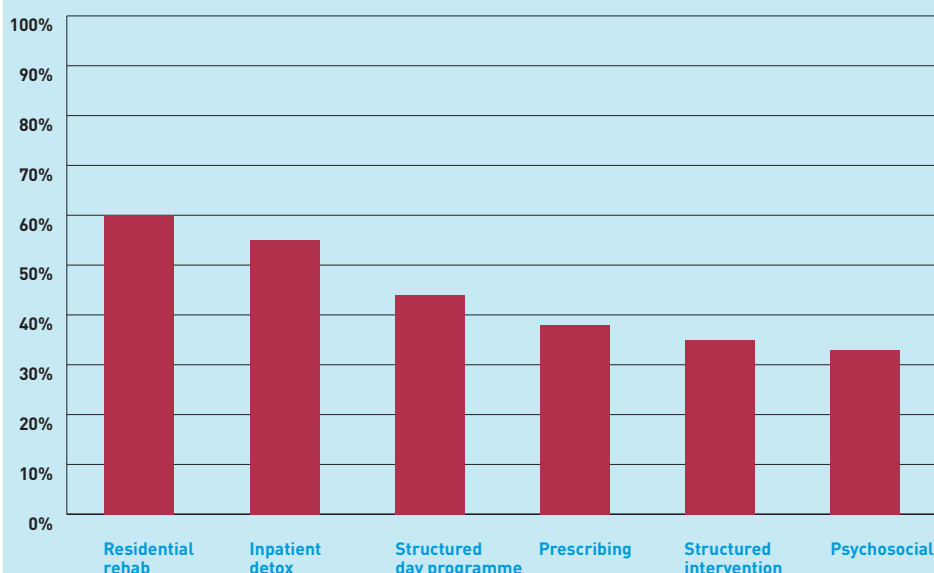
Relative performance among residential providers

In the new local public health system, all treatment providers will have to deliver value for money. Local authorities will take over their new role as commissioners, well aware they will have to balance local demand with shrinking budgets and juggle drug and alcohol treatment against other public health priorities.

If residential rehab providers can demonstrate clinical and cost effectiveness, their services will continue to be purchased from public funds. If they can't adequately show value for money, there is a real risk of disinvestment by local commissioners.

When it comes to assessing the outcomes of individual providers, performance varies across the sector. The very best rehabs see three-quarters of their residents overcome addiction, but at the other end of the spectrum the proportion is less than 10%.

3. Proportion of users accessing each type of service in treatment for both heroin and crack



“A number of services are clearly providing excellent value for money to their commissioners... others are struggling to deliver results”

Figure 4 shows an anonymised breakdown by individual providers of the proportion of their 2010-11 residents who successfully completed treatment and overcame dependency. This covers the 73 rehabs submitting returns for more than 10 people in the year, excluding 28 agencies with very small numbers.⁸

These providers are ranked according to the percentage of residents who successfully completed treatment, either directly from the residential rehab or following a period of further structured support in another part of the treatment system. The list therefore endeavours to capture anyone for whom a recent treatment episode in residential rehab contributed to their successful recovery outcome.

The table indicates a number of high-performing services are providing excellent value for money to their commissioners and quality outcomes for service users. About a dozen can claim 60% or more of their residents go on to overcome their dependence, with or without the help of other community services.

However, there are also a significant number of residential providers who are clearly struggling to deliver results. About a half of all residents at over half of all rehabs do not overcome their addiction. A minority have a success rate of only 20% or under.

There is no clear relationship between the complexity of users, the costs of services, and the performance outcomes achieved by individual providers.

Alcohol

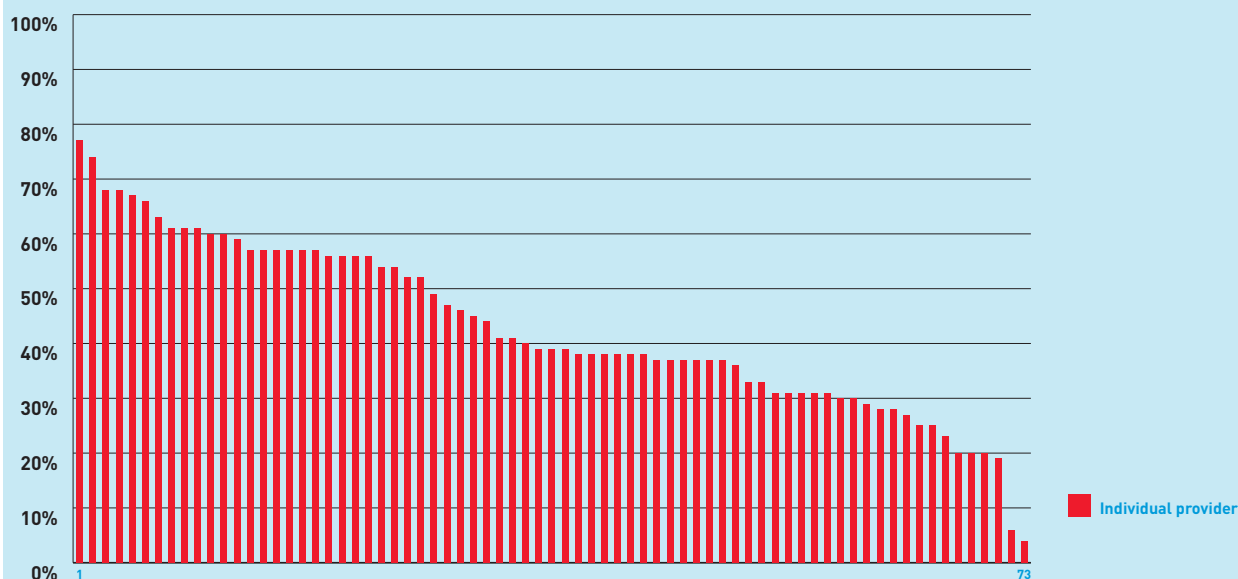
Most residential rehab facilities also treat people with severe alcohol dependency. Although the number of people in treatment for alcohol dependency in England (about 110,000) is much smaller than the drug treatment population, the proportion in residential rehab (3%) is similar.⁹

Nevertheless, analysis shows that outcomes were consistently better for the 3,881 alcohol users in 2010-11 who spent some time in residential rehab as part of their treatment pathway.

For example, 38% of alcohol users left the treatment system directly from residential rehab, having overcome their dependency and having no further structured treatment need, compared to the 28% of rehab drug users. The overall drop-out rate was also lower, with 24% of alcohol users leaving rehabs prematurely, compared to 36% of drug users.

One possible explanation for this discrepancy is that dependent drinkers are easier to treat than people with entrenched and

4. Proportion of residential rehab clients 2010-11 who successfully completed treatment, by individual provider



“Residential rehabilitation is a vital and potent component of the drug and alcohol treatment system – one potential element of a successful recovery journey”

complex patterns of drug use. The personal resources they bring to the challenge of overcoming addiction, such as motivation and determination, and the social and family support available to help them, may mean that dependent drinkers have more recovery capital on which to draw than a person with a complex history of drug use.

Conclusion

Residential rehabilitation is a vital and potent component of the drug and alcohol treatment system and should continue to be so – not as a separate treatment setting, or as an alternative to community treatment, but as one potential element of a successful recovery journey.

At a system level, this means people will usually spend some time in community treatment before completing a residential rehab programme, and then either return to community based services afterwards or exit the treatment system completely.

The key focus for service users, commissioners and providers alike is successful treatment outcomes. Yet in an increasingly outcomes-focused local public health system, all treatment services will need to be able to demonstrate value for money.

Those providers that are able to consistently demonstrate they add value, by achieving good outcomes for their clients, will find their services continue to be commissioned. Those that can't prove value for money will be at risk in an unforgiving financial environment.

Although the capacity and capability of community drug treatment has improved significantly over the past decade, there will always be some people who can benefit from extra specialist and intensive help. Residential rehabs can add value here by treating the more complex people with drug problems and helping them to recover.

This analysis has identified a segment of the residential rehab sector that significantly contributes towards recovery from drug and alcohol addiction, either independently or as part of a wider, recovery-focused system.

Nevertheless, some providers do need to improve their performance if they are to maintain their position in the drug treatment market. The NTA is continuing to work with the Recovery Partnership and the rehab sector in order to raise the standards of the poorest performers and enable them to meet the level of their high-performing peers.

NOTES

¹HM Government (2010) 'Drug Strategy 2010: reducing demand, restricting supply, building recovery: supporting people to live a drug free life.'

²The Recovery Partnership is an umbrella group comprising the Substance Misuse Skills Consortium, the Recovery Group UK and the charity DrugScope, that seeks to be a collective voice engaging with government on the aims and ambitions of the Drug Strategy. The rehab membership organisation EATA was also party to the early discussions but has since merged with DrugScope.

³The Pooled Treatment Budget, which combines funding for community treatment from the Department of Health and the Home Office, was worth £406m in 2010-11. Funding for prison treatment and criminal justice interventions was provided separately.

⁴NICE (2007) 'Drug misuse: psychosocial interventions.' Clinical Guideline 51.

⁵The average annual unit cost of community treatment for a heroin addict is about £2,000. The comparable annual figure for treatment that includes residential rehab is about £10,000. This includes time spent in community-based services as well as the cost of a 13-week rehab programme and the cost of inpatient detoxification beforehand.

⁶The NTA has hosted a series of events for representatives of residential providers, including a seminar on 26 January 2012 where an early analysis of

NDTMS data for 2010-11 was discussed. Subsequent findings from the audit have been shared with the residential sector via the Recovery Partnership.

⁷NTA (2011) 'Statistics from the NDTMS, 1 April 2010-31 March 2011'.

⁸Not all residential rehabs submit data to NDTMS. For example, one of the best-known rehabs, The Priory Group, takes private clients but is not commissioned by any local partnership.

⁹NTA, DH (2012) 'Statistics from the National Alcohol Treatment Monitoring System (NATMS), 1 April 2010-31 March 2011'.