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Residential rehabilitation: the high road to recovery?

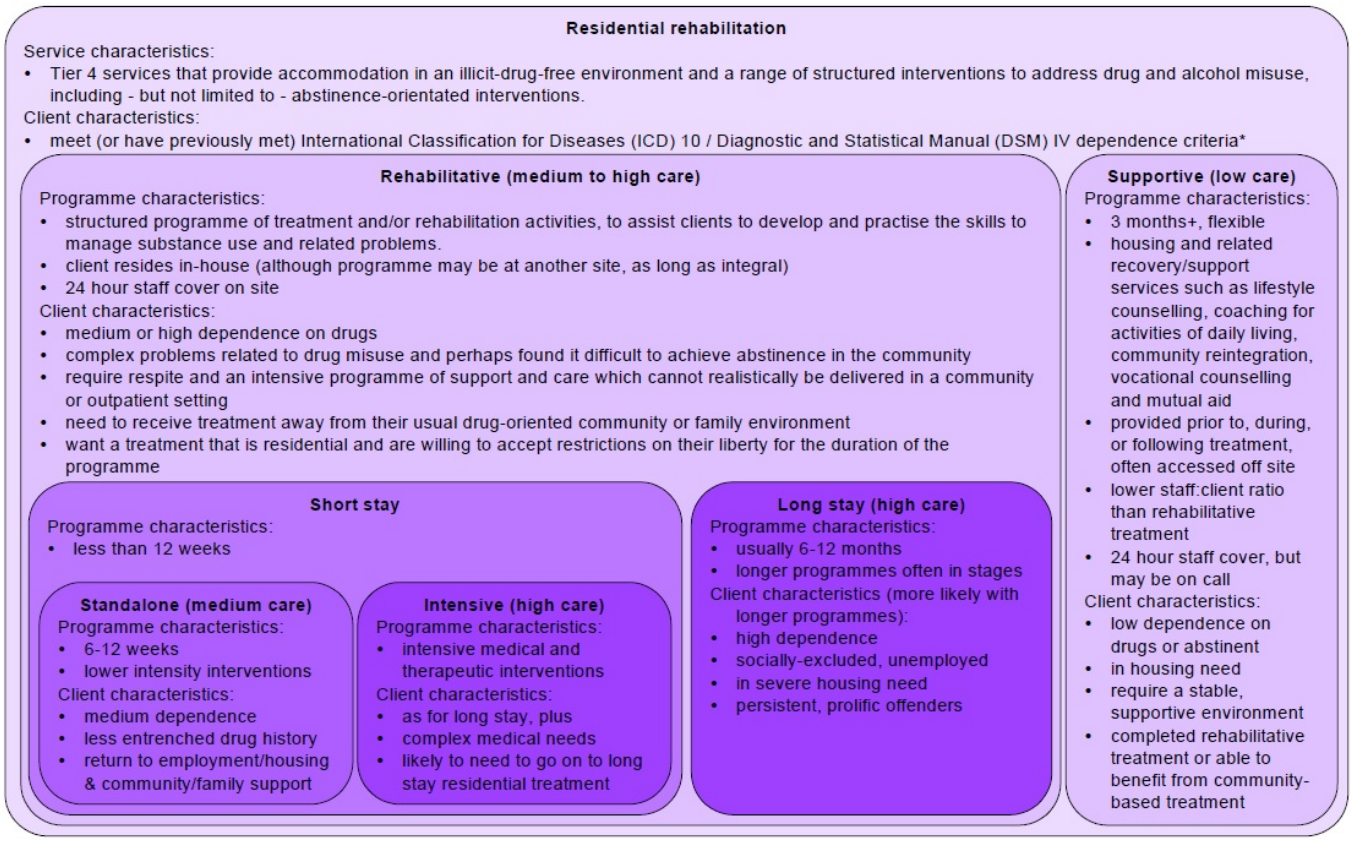
> *"I would like to … try to provide – difficult though it will be given the shortage of money we have been left – more residential treatment programmes. In the end, the way you get drug addicts clean is by getting them off drugs altogether, challenging their addiction rather than just replacing one opiate with another."*

These comments, made by former Prime Minister David Cameron in August 2010, were reiterated in February 2015 when he said he remained "committed to funding residential, abstinence-based rehabilitation, difficult though it may be in the current climate. Rather than maintaining people on substitutes like methadone, we have to help more people get off drugs and into work." His words both reflected and promised to embed in policy the current emphasis on treatment which explicitly aims for recovery, reintegration and abstinence, trends which in turn have focused attention on what has been seen as the treatment best suited to all three – residential rehabilitation. However, add the claim that residential treatment has been side-lined in pursuit of 'manage the problem' objectives, and the fact that they are among the most expensive options at a time of financial cutbacks, and you have a combustible mixture.

What does residential rehabilitation have to offer?

'Residential rehabilitation' is the umbrella term for programmes which require residents to stay overnight at a facility to receive treatment, and typically expect residents to be drug and alcohol free before they start (though in some cases detoxification is offered by the centres themselves as the first of the treatment). Beyond these common factors, programmes may differ according to their philosophy, intensity, inclusion criteria, programme content, and duration.

One simple way to look at what residential rehabilitation has to offer is to break it down into those with rehabilitative versus supportive goals: rehabilitative programmes provide a structured, care-planned programme of therapeutic and other activities; whereas supportive programmes provide specialist drug/alcohol and related support, often following treatment in a rehabilitative programme, but no structured therapy (▶ illustration).



Models of residential programmes (National Treatment Agency for Substance Misuse)

Characteristics of effective residential rehabilitation, according to the National Treatment Agency for Substance Misuse, include:

- Comprehensive assessments of clients
- Respecting client choice
- Planning and reviewing care (as well as departure and aftercare)
- Attention to housing, education, training, and employment support needs
- Developing social and life skills

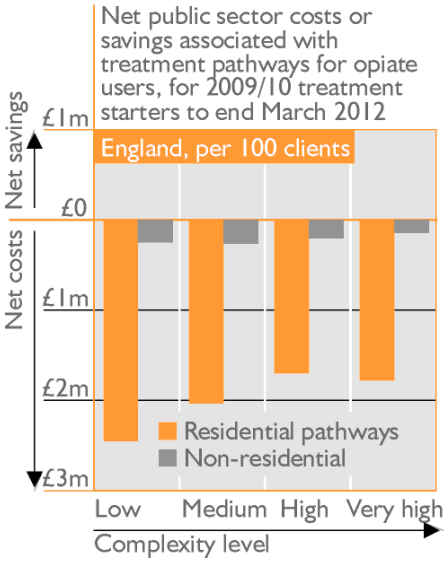
A useful set of quality standards have been developed by the Recovery Partnership (formed in 2011 by DrugScope, the Recovery Group UK, and the Substance Misuse Skills Consortium). These are intended to help providers demonstrate the quality of residential rehabilitation to commissioners, purchasers, clients, and their families.

A good investment?

The present government remains focused on reducing public expenditure and welfare spending. Consequently, the relatively high cost residential rehabilitation is expected to show that it could save the Exchequer more than non-residential treatments dominated by opiate substitute prescribing.

Based on the 2009/10 treatment intake for England, a study was undertaken by the Department for Work and Pensions, whose then leader Iain Duncan Smith had forefronted welfare benefit constraints and backed the 'full recovery' drug-free rehabilitation options exemplified by residential rehabilitation, while condemning reliance on opiate substitute prescribing.

Though set up to determine whether the public purse would gain by sending more opiate-dependent clients to residential rehabilitation, in the end his department's study declared itself unable to conclude one way or the other, but did judge it "highly unlikely" that these treatments' extra expense would be offset by extra savings. If anything, the report suggested that non-residential, prescribing-dominated options were a better deal for society in its attempts to contain public sector costs, when these costs include the costs of treatment itself ▸ chart. It must have been a special concern that welfare spending uniformly moved in the 'wrong' direction after entering treatment, and the resultant losses to the Exchequer were particularly steep in respect of clients on treatment pathways which featured residential rehabilitation, presumed to be due to their stabilisation and the advice and help they received to claim their entitlements.



But if it was not clearly best for the public purse, for the patients and their families, residential rehabilitation might still have been considered a good investment. As defined by the study (entailing planned treatment exit and non-return), patients on pathways which included residential rehabilitation were consistently more likely to register positive treatment completions than those on entirely non-residential pathways. For example, 16% of very high complexity clients left residential pathways successfully with no later records indicative of relapse compared to just 6% whose treatment had not included residential rehabilitation. At the other end of the scale, for low complexity clients the corresponding figures were 31% and 21%. Beyond purely financial considerations is the argument that medical and allied treatments, including the treatment of addiction, are not primarily undertaken to save money for the public sector, but to use that money to relieve illness and distress. On this count residential rehabilitation scores relatively heavily.

One gap in the study was its limited data on the psychological differences between residential and non-residential pathway clients which might have affected their chances of recovery, regardless of the treatment option. Drawing its data from a national study of patients starting drug treatment in England in 2006–2007, an analysis examined this issue for opiate users, the same type of patients included in the study from the Department for Work and Pensions. It found that compared to those prescribed substitute drugs such as methadone, opiate users whose treatment had included residential rehabilitation were from the start more ambitious for their future and more motivated and ready to recover through treatment. The differences were not huge, but enough for the researchers to suggest that "higher treatment motivation in [residential rehabilitation] participants may account for the effectiveness of [residential rehabilitation] compared with other treatment modalities," and that sending more patients to residential rehabilitation without ensuring they are sufficiently motivated is "unlikely to lead to an expansion of successful treatment outcomes."

A 2010 review found that comparative studies of the cost-benefits of residential and non-residential treatments are actually few and far between. It challenged the widespread assumption that community-based treatments 'must' be the cheaper option, reporting that only a small number of studies had findings to this effect, and these "were less thar definitive". One study concluded that the benefits of residential treatment may be realised over a much longer time frame than accommodated in most research, advocating follow-up periods closer to six years than one or two years.

A last resort?

In 2011, concerned that they were being side-lined, British residential services banded together in a Concordat to promote their cause as "providers of full recovery", defined as moving towards a drug-free, productive and socially integrated life. Their terminology was echoed the following year in a highly contested follow-up to the national drug strategy entitled Putting full recovery first, described by the chair of the Inter-Ministerial Group on Drugs as "the Government's roadmap for building a new treatment system based on recovery". What it meant by "full recovery" was never spelled out, nor how it differs from plain "recovery", but adopting this objective was said to entail an "increased focus on abstinence-based treatment" and a relegation of "indefinite maintenance, which is a replacement of one dependency with another" to the periphery rather than the centre of opiate addiction treatment.

A survey of (16 of 28) members of the Concordat highlighted a lack of referrals, related to the common insistence (1 2) by local authority funders of residential care that prospective residents must first have exhausted other treatment options, and unrealistically proved their commitment to rehabilitation by complying with preparatory work, when the

reason for their referral is precisely that they have been unable to overcome their dependence without the shelter of a residential setting. All but four respondents reported that "their service was under threat of closure for 2010/11".

Though there was no immediate prospect of wholesale closure, a survey in 2014 of services in England and the commissioners largely responsible for funding them suggested that residential services had cause to be worried. Funding levels had yet to dramatically change, but 44% of services said adult social care funding had fallen and just 18% that it had increased, while twice as many commissioners (33%) foresaw their funding of these services falling as predicted it to rise (16%). Over two-thirds (70%) reported they had recently commissioned more non-residential abstinence-based services, while twice as many (about a third) thought their spending on residential services would decrease than increase. Just how precarious things had become was evident in the finding that six in ten services had recently felt under threat of closure. In what could become a vicious cycle, it seemed service quality was beginning to suffer, diminishing the difference between residential and non-residential provision, and offering further reasons for transferring funding to cheaper non-residential provision. Nevertheless, up to year 2013/14 occupancy levels and numbers in residential treatment held up well.

Commissioners who insist residential care should be a last resort can and do claim the authority of Britain's National Institute for Health and Care Excellence (NICE). Based partly on not even a handful of studies recording no overall advantage for residential care over alternatives, NICE's experts advised that residential treatment be reserved for substance users with "significant comorbid physical, mental health or social (for example, housing) problems", who should have "not benefited from previous community-based psychosocial treatment."

Most influential among the studies reviewed for NICE was a randomised comparison of a non-residential day therapeutic community versus a residential version for US crack users. It found no lasting anti-relapse benefits from the residential setting but – as in several other trials – the researchers had to limit the severity of their subjects so that all could safely be sent to either residential or non-residential care. The result was that nearly three-quarters of potential participants could not join the study, and those who could were the ones least likely to need and differentially benefit from residential care.

Critics of NICE's 'last resort' position argue that the reason why some clients are in such poor mental, physical and/or social states is that residential rehabilitation had been denied them earlier in their drug using careers when they had a greater chance of succeeding before the deterioration became too deep. The opposing argument is that trying residential services first risks unnecessary expenditure which drains treatment resources because it is impossible to predict with any certainty who will do well and who badly after their spell at the rehabilitation centre.

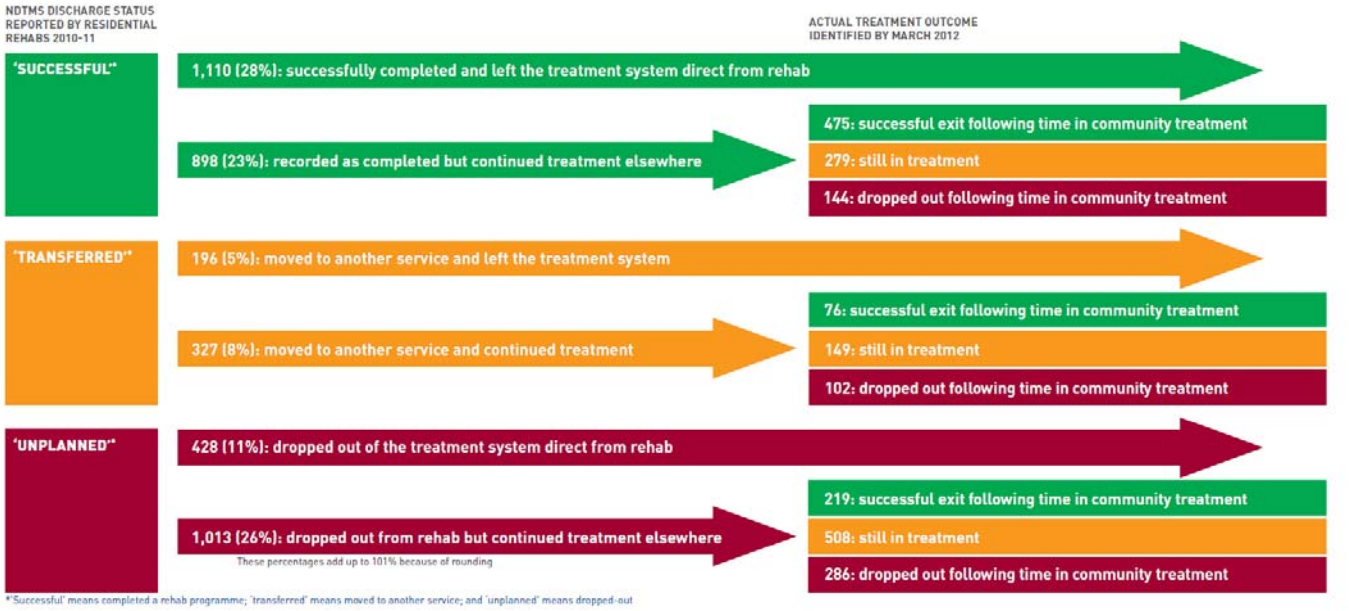
NICE have briefly alluded to the success of residential rehabilitation for people further down the scale of severity in their guidance, saying that "While traditional practice in the UK has been for service users to be referred for residential treatment when they have failed a long period of community care, there is some evidence to suggest that those less well established in their drug using careers may benefit from residential care". However, this point was not examined in any further detail, nor reflected in their recommendations.

Limitations as well as advantages

A distinctive feature of residential rehabilitation is the 24-hour-a-day sheltering of the patient in a setting away from home – a protected environment far removed from the temptations and pressures which helped sustain the client's addiction. What might sound like ideal conditions was interpreted differently by William White, US guru of re-orienting treatment and allied systems to recovery objectives and principles. In his key work on systems of care he pointed out that the non-recovery oriented systems he seeks to transform "grew out of a tradition of isolating addicted persons from their natural physical and social environments [to] enter a closed therapeutic environment" such as a residential treatment programme or therapeutic community. As he saw it, the problem was that learning to live without drugs there is likely to be unlearnt on transfer to a different environment: "The greater the physical, psychological, social, and cultural distance between the treatment environment and the natural environment of the client, the greater will be this transfer-of-learning challenge." Part of the solution, he argued, is a "greater emphasis on delivering home- and neighborhood-based (eg, health clinics, neighbourhood centers) addiction treatment and recovery support services" – the antithesis of the traditional model of residential rehabilitation in Britain. Considering these points in light of his experience in UK residential treatment, professional Dominic McCann said the following: "To my mind the "transfer of learning challenge" is White's critique of the old therapeutic communities, with their highly artificial cultures and lengthy treatment programmes. But in modern/medical models of residential treatment, the patient is away from home for shorter periods, and treatment centres go to great lengths nowadays to prepare patients for reintegration and relapse prevention."

For those who choose residential rehabilitation, follow-on treatment or support may be needed, especially due to the inherent challenges of sustaining sobriety in everyday life, and the elevated risk of overdose after leaving residential treatment. The ▸ illustration below highlights some data from a 2012 audit, showing that "when people complete their treatment at 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 proportion of clients *successfully completing treatment* was defined as "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 treatment journey of 3,972 residential rehabilitation residents



Residential rehabilitation can have great advantages for people who need respite, shelter and wrap-around care, but is rarely a one-off solution to the deep-seated and multiple problems of the typical resident. Also for some, entering a 'home' may be too distressing or disruptive to countenance, particularly if it involves separation from their family. A UK report on women's treatment needs pointed out that placing women in residential services *without* their children is not too dissimilar to sending them to prison, where travel costs and time may limit the amount of contact with their children. Such stressors could understandably impact on their ability and resolve to complete treatment and rehabilitation (an argument which would apply to others too). NICE states that "the needs of people with children should be considered so that children are appropriately looked after while their parents enter residential rehabilitative treatment", which according to the National Treatment Agency for Substance Misuse could include accommodation for the whole family, as well childcare facilities while residents are in counselling or groupwork, and family therapeutic and education interventions, such as parenting education – though one would expect these facilities to be hard to come by.

Research prospects

Douglas L. Polcin examined the strengths and weaknesses of different research designs for studying residential rehabilitation treatment. He identified a "host of important factors that need attention", in order to generate findings which "are more informative, intuitively appealing, and interpretable". This includes research into understudied areas, and the resolution of challenges with randomised trials versus more naturalistic/real-life research methods.

Randomised trials are generally considered the 'gold standard' in research, but in comparing non-residential to residential rehabilitation, they are usually forced to exclude people whom it would be unsafe or unethical to leave 'on the streets', the very people who might benefit most from a residential option. This design can create a "false comparison". The random allocation aspect that enables researchers to draw conclusions about cause and effect may also be obscuring or eliminating an important step in recovery: the *mutual selection* process between the applicant and the recovery home, where residents enter the residential environment because they are a good match, not because they were assigned there. Further research using random assignment could consider "assign[ing] individuals to a broad recovery home condition that allows individuals to pursue residence in different recovery houses rather than one specific house", allowing for some degree of mutual selection, or "assign[ing] residents to an enhanced recovery house condition versus recovery housing as usual after they enter the house".

Additional research would be beneficial in the following areas: residential homes for specific populations (eg, criminal justice, women with children, and sexual minority groups); architectural features that influence social interaction and neighbour perceptions; homes that can accommodate low income, inner-city residents; and good candidates for different levels of service intensity.

See what the researchers have discovered by running this hot topic search – but beware that no conclusive answer to the residential v. non-residential question can be found. Our reading of the research is that while non-residential care is sufficient for many clients, residential care has particular benefits for the minority who are most severely affected. For this topic we are also making available these unpublished notes on studies comparing residential and non-residential care.

Thanks for their comments on this entry in draft to Rowdy Yates, President of the European Federation of Therapeutic Communities. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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